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	255328	A. BUILDING _____ B. WING _____	C 11/16/2023

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	F 000		

The State Agency (SA) conducted a Complaint Investigation (CI MS #23271), at the facility from 11/13/23 through 11/16/23. During the survey, the SA determined the facility failed to implement their own plan of correction and remains out of compliance with the requirements for participation in Medicare and Medicaid from CI MS #22783 conducted on 10/5/23. The SA investigated the complaint for resident neglect and cited F600 and F656.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 10/18/23 when facility staff neglected to accurately complete weekly body audits for Resident #1, which resulted in the amputation of her 5th digit on her right foot.

The facility failure to accurately perform body audits caused Resident #1 to undergo an amputation and placed other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death.

The IJ and SQC existed at:

CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity "J"

The IJ existed at:
CFR §483.21(b) Comprehensive Care Plans - F656 - Scope/Severity "J"

The facility Administrator was notified of the IJ and SQC on 11/15/23 at 12:12 PM and the IJ templates were provided to the Administrator.

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

Electronically Signed | 11/22/2023

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F 000	Continued From page 1 The facility provided an acceptable Removal Plan on 11/15/23, in which they alleged all corrective actions to remove the IJ and SQC were completed on 11/15/23 and the IJ removed on 11/16/23. The SA validated the Removal Plan on 11/16/23 and determined the IJ was removed on 11/16/23, prior to exit. Therefore, the scope and severity for CFR 483.12 Freedom from Abuse, Neglect, and Exploitation and CFR 483.21(b) were lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 77, and the facility held a license for 120 beds.	F 000		
F 600 SS=J	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	F 600		12/7/23

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F 600	Continued From page 2 by: Based on staff and Resident Representative interviews, record review, and facility policy review, the facility failed to protect the resident's right to be free from neglect when staff provided inaccurate body audits and services for one (1) of four (4) sampled residents. Resident #1 The facility's failure to ensure that body audits were completed accurately resulted in Resident #1 sustaining an amputation of the fifth digit of her right foot and placed other residents in a situation that was likely to cause serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 10/18/23 when facility staff completed an inaccurate weekly body audit. The facility Administrator was notified of the IJ and SQC on 11/15/23 at 12:12 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 11/15/23, in which they alleged all corrective actions to remove the IJ were completed on 11/15/23, and the IJ removed on 11/16/23. The State Agency (SA) validated the Removal Plan on 11/16/23 and determined that the IJ was removed on 11/16/23, prior to exit. Therefore, the scope and severity for CFR 483.12 Freedom from Abuse, Neglect, and Exploitation-F600 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	F 600	1. Resident #1 was sent to the Emergency Room on 11/7/23 and discharged from the facility on 11/9/23. 2. All Residents have the potential to be affected by the same deficient practice. 3. Nursing Staff were inserviced beginning on 11/15/23 by an outside facility Director of Nursing on reporting skin issues, reporting undated dressings, and the correct process to conduct a body audit, accurate documentation and following the careplan. All nursing staff will be inserviced by 11/22/23. All residents had a baseline body audit completed by the Director of Nursing, Resident Care Coordinator, and RN Supervisor on 11/22/23. All nursing staff that conducts body audits will complete skill check off with DON, RCC, and Staff Development nurse by 12/1/23 to include detailed review of all parts of the body. 4. Director of Nursing will visualize current wound and compare to most recent body audits weekly x 12 weeks beginning 11/16/23. The Resident Care Coordinator or Director of Nursing will complete 15 body audits previously completed by assigned nurse 50% of the 15 residents will be cognitive impaired this will began 11/16/23 weekly x 12 weeks to verify that body audit is completed accurately. All audits will be reviewed by the Quality Assurance and Assessment Committee x 3 months beginning 12/06/23 to ensure sustained compliance.	

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F 600	Continued From page 3	F 600		

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 11/1/22, revealed, "...It is our policy to perform a full body skin assessment as part of our systematic 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 ..."

Record review of the facility's "Resident Incident, Complaint or Information Report", dated 11/13/2023, revealed, " ...On 11/7/23, Resident was noted to have a discolored right fifth toe. The nurse assessed resident's foot, noting discoloration and a small bandage on the toe. Resident sent out to hospital for evaluation. Course of treatment in hospital was amputation related to infection of the toe ..."

A record review of the hospital "Discharge Summary", dated 11/9/23, revealed ..."ADM (admission) Date: 11/07/23 ...Discharge Diagnoses: Infection right fifth toe ...Underwent amputation right fifth toe on 11/08/2023.. **ADDENDUM** ...On exam, the toe appears ischemic ...Unfortunately, she seems to be developing some infection within the ischemic toe. I have recommended amputation today...

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F 600	Continued From page 4 ...Assessment and Plan ...(1) Gangrene of toe Status: Acute..Right fifth toe malodorus ...Exam: ...Extremities right fifth toe malodorus and necrotic at the distal end with erythema progressing more proximally ..." During an interview with the Administrator on 11/13/23 at 12:10 PM, he stated that Resident #1 was treated by the Podiatrist Nurse Practitioner (NP) on 10/18/23. He stated the Podiatrist NP performed nail care and wrapped the resident's fifth right toe (small toe) with a pink cohesive bandage. The Administrator agreed the facility staff did not perform skin or body audit correctly for Resident #1 on 10/18/23, 10/25/23, and 11/1/23 and this caused Resident #1 to undergo an amputation of her toe. On 11/13/23 at 12:54 PM, an interview with the facility's Nurse Practitioner (NP), confirmed that on 11/7/23, she was requested to go to Resident #1's room by Registered Nurse (RN) #1 and the Resident Care Coordinator (RCC) to evaluate the resident's right fifth toe. She stated that upon her evaluation, the resident's toenail area was approximately 50 % necrotic (dead tissue) and had black discoloration. Also, towards the resident's foot, the toenail area had a red and purple discoloration. The NP notified the Medical Director, Administrator, the Director of Nurses (DON), the Resident Representative (RR), and emergency services after her evaluation. The NP stated that the Occupational Therapist (OT) reported that Resident #1 had complained of pain in her right foot/toe area and the OT observed the pink bandage around the resident's toe. The OT then notified RN #1 who had removed the bandage, which was reportedly very tight.	F 600		

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On 11/13/23 at 1:15 PM, during an phone interview with the Podiatry NP, she revealed that on 10/18/23, she treated Resident #1 for dystrophic (deformed, thickened, or discolored) nails. The podiatry NP stated she remembered that the resident had some bleeding on her fifth right digit area, but it subsided with pressure. She denied putting a bandage on the resident's toe but confirmed that she used pink Coban bandages when treating residents. She reported that her visit on 10/18/23 was her first time to be in the facility and verified that she did not report to facility staff following her treatment of the residents. She stated that she thought the facility nurses, or the facility NP, would read her documentation and follow up as needed. She confirmed she did not write or recommend any treatment for Resident #1. She also stated that her documentation was for her left fifth digit, but she was unable to remember if it was for the left or right.

A record review of "Health Services Progress Note", with an encounter date of 10/18/23, completed by the Podiatry NP, revealed " ...Performed debridement of nine nails (all except left fifth nail) for reduction of thickness and length. Left fifth toenail came off spontaneously as I cleaned it gently with adult skin wipe before debridement began. Nail bed oozed a small amount of blood. Bleeding stopped after I applied pressure with clean gauze ..."

In a phone interview on 11/13/23 at 1:40 PM, with the Resident Representative (RR), she stated that on 11/7/23, she received a phone call from the facility NP, who reported that her mother (Resident #1) was noted to have a pink dressing on her toe and was being transferred to the local

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emergency department for an evaluation.

On 11/13/23 at 2:34 PM, during an interview with Certified Nurse Assistant (CNA) #1, she confirmed that during Resident #1's baths, she had observed a bright pink bandage around the resident small right toe. CNA #1 stated that the resident did not complain of any pain during any of her baths. During the interview with CNA #1 confirmed that she normally was assigned to Resident #1.

On 11/13/23 at 3:00 PM, during an interview with RN #1 confirmed the OT requested she come to Resident #1 room to evaluate her foot. RN #1 stated upon seeing the pink dressing on the toe, she immediately attempted to remove it with her surgical scissors but it was so tight around her toe. She used a pair of suture scissors to remove the bandage and the toe bed area was black with purple and redness discoloration proceeding down the toe area.

Record review of the " ...Skin Only Evaluation", dated 10/25/23, revealed License Practical Nurse (LPN) #1 documented that Resident #1 did not have current skin issues.

During a phone interview on 11/14/23 at 2:00 PM, LPN #1 stated that she performed the skin/body audit on Resident #1 on 10/25/23. LPN #1 confirmed she failed to remove the resident's socks to assess her feet and toes. She explained she was unaware that Resident #1 had a bandage on her right toe.

Record review of the " ...Skin Only Evaluation", dated 10/18/23 and 11/1/23, revealed LPN #2 documented that Resident #1 did not have

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current skin issues.

On 11/14/23 at 2:30 PM, a phone interview with LPN #2 confirmed that she documented the skin/body audits on Resident #1 on 10/18/23 and 11/1/23. LPN #2 stated that she did not actually perform the body audits but had asked a CNA on 10/18/23 and 11/1/23 to ascertain if the resident had any marks or sores on her body and was told the resident had none. LPN #2 confirmed that she failed to perform the body audits herself. She explained she did not know there was a bandage on Resident #1's right foot.

On 11/14/24 at 2:42 PM, during an interview with the OT, she confirmed that on 11/7/23, she was assisting Resident #1. The resident requested her socks to be changed to match her outfit and when she removed her socks, she observed a pink bandage on her right foot, fifth digit. The resident jumped while removing the sock on her right foot and complained of pain in her foot area. The OT notified RN #1, who came to her room and removed the dressing. During the removal of the pink dressing the OT confirmed that the dressing was tight and difficult for the nurse to remove. Following the removal of the dressing, the residents toe looked black in color.

During an interview with the Administrator on 11/14/23 at 3:00 PM, he stated that he expected the nursing staff to do a complete head-to-toe skin assessment to prevent further damage to a compromised resident.

During an interview on 11/14/23 at 3:56 PM, with the DON, she confirmed the staff failed to perform accurate head-to-toe body audits on Resident #1, and she was unaware that was not

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being performed correctly. The DON also confirmed that she was unaware the resident had a Coban dressing on her right fifth toe for 20 days, which was not assessed by staff which caused the resident to have an amputation. The DON stated the facility had been performing and continuing to perform in-services to nursing staff on head-to-toe body audits.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/9/22 with diagnoses including Psychotic Disturbance, Mood Disturbance, Anxiety, Hypertension, and Autonomic Neuropathy.

Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/17/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated she was severely impaired.

The facility submitted the following acceptable Removal Plan on 11/15/23:

On 11/15/23 at 12:12pm, the State Survey Agency notified the Administrator that the facility 1.) neglected to provide accurate body audits and services to Resident #1 from 10/18/23 until 11/7/23, as evidenced by staff admission of incomplete body audits, resulted in Resident #1 sustaining an amputation of the fifth digit of her right foot. 2.) failed to implement care plan interventions for Resident #1 when the facility failed to provide complete and accurate weekly body audits from 10/18/23 through 11/7/23.

The Immediate Jeopardy Templates for F600 and F656 were provided to the Administrator on 11/15/23, at 12:12pm.

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At Approximately 12:00pm on 11/7/23, Occupational Therapist (OT) notified Registered Nurse #1 that Resident was experiencing discomfort of a toe on her right foot. RN #1 and Resident Care Coordinator/Infection Preventionist (RCC/Infection Preventionist) removed a pink bandage from the toe and requested that Nurse Practitioner evaluate Resident. Nurse Practitioner noted the right fifth toe to be necrotic at the nail bed, with plantar surface to have red and purple discoloration proceeding down the toe. Nurse Practitioner sent the Resident to the hospital for further evaluation and treatment. Resident was admitted to hospital 11/7/23, underwent surgery for toe amputation related to infection on 11/8/23, and discharged from the facility per family request on 11/9/23.

On 11/7/23, the facility initiated an investigation. The type of pink dressing found on Resident's foot is not a type purchased or used by the facility. Podiatry Nurse Practitioner saw Resident on 10/18/23. Interview revealed Podiatry Nurse Practitioner did use this type of pink dressing and stated to facility staff that she did use this type dressing on Resident. Her visit documentation did not indicate a dressing was applied.

Body audits conducted on 10/18/23 and 11/1/23 by LPN #1 did not indicate dressing present. Body audits conducted on 10/25/23 by LPN #2 (Agency) did not indicate dressing present. Due to inaccurate assessments, employment of LPN #1 was ended on 11/7/23 and the agency notified on 11/7/23 that LPN#2 (Agency) would not be allowed to work in the facility again.

On 11/7/23, Staff Development Nurse initiated

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training of nursing staff to include reporting skin issues, reporting undated dressings, correct process to conduct a body audit, and accurate documentation. No nursing staff members were allowed to work until trained.

On 11/7/23, Director of Nursing (DON) and RCC/Infection Preventionist conducted 15 verification audits of documented body audits to ensure accuracy. No errors in accuracy of documentation were found.

On 11/10/23, potential for skin problem care plans were reviewed on 76 residents with no changes made. Reviews conducted by MDS Nurse #1 and MDS Nurse #2.

On 11/7/23 DON and RCC/Infection Preventionist conducted a visual evaluation of the feet of all residents who received podiatry services on 10/18/23 with no skin problems noted. These were conducted due to interview with Podiatry Nurse Practitioner in which she stated she was uncertain of which residents she may have left bandages on.

Quality Assurance Committee (QAC) recommendation of 11/7/23 implemented that all future Podiatry in-facility visits will be accompanied by a nurse for a minimum of two (2) months. Additional requirement made that Podiatry staff exit with DON, RCC/Infection Preventionist or RN Supervisor prior to leaving the facility at the end of each visit.

QAC meetings conducted on 11/7, 11/9 and 11/10/23 to review investigative steps and corrective actions taken.

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On 11/11/23 and 11/12/23, body audits were conducted by the DON accompanied by the Administrator on seventy-five (75) residents. Body audits on all residents were completed by 11/14/23.

On 11/13/23 LPN #1 and LPN #2 were reported to the Mississippi (MS) Board of Nursing.

On 11/15/23 training conducted at 2:30pm on reporting skin issues, reporting undated dressings, correct process to conduct a body audit, and accurate documentation presented by an Outside Facility Director of Nursing. No nursing staff will be allowed to work until they have been trained.

Emergency Quality Assurance committee meeting was conducted 11/15/23 at 1:45pm. Attending the meeting were Administrator, DON, RCC/Infection Preventionist, Medical Director (via phone), Social Services, OT, MDS Nurse #1 and MDS Nurse #2. Discussed in the meeting were: Recap of incident and investigation involving Resident #1, which had been reviewed in QAC meetings on 11/7, 11/9, and 11/10, Corrective actions taken, and Review of policies related to neglect, skin audits and care plans.

The facility implemented all corrective measure on 11/15/23 and alleges the immediate jeopardy was removed 11/16/23.

The SA validated the removal plan on 11/16/23 and immediacy removed on 11/16/23 prior to exit.

The State Agency (SA) validated the facility's removal plan on 11/16/23.

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The SA validated through interview and record review that at approximately 12:00pm on 11/7/23, Occupational Therapist (OT) notified Registered Nurse #1 that Resident was experiencing discomfort of a toe on her right foot. RN #1 and Resident Care Coordinator/Infection Preventionist (RCC/Infection Preventionist) removed a pink bandage from the toe and requested that Nurse Practitioner evaluate Resident. Nurse Practitioner noted the right fifth toe to be necrotic at the nail bed, with plantar surface to have red and purple discoloration proceeding down the toe. Nurse Practitioner sent the Resident to the hospital for further evaluation and treatment. Resident was admitted to hospital 11/7/23, underwent surgery for toe amputation related to infection on 11/8/23, and discharged from the facility per family request on 11/9/23.

The SA validated through interview and record review that on 11/7/23, the facility initiated an investigation. The type of pink dressing found on Resident's foot is not a type purchased or used by the facility. Podiatry Nurse Practitioner saw Resident on 10/18/23. Interview revealed Podiatry Nurse Practitioner did use this type of pink dressing and stated to facility staff that she did use this type dressing on Resident. Her visit documentation did not indicate a dressing was applied.

The SA validated through interview and record review that body audits were conducted on 10/18/23 and 11/1/23 by LPN #1 did not indicate dressing present. Body audits conducted on 10/25/23 by LPN #2 (Agency) did not indicate dressing present. Due to inaccurate assessments, employment of LPN #1 was ended on 11/7/23 and the agency notified on 11/7/23 that

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LPN#2 (Agency) would not be allowed to work in the facility again.

The SA validated through interview and record review on 11/7/23, Staff Development Nurse initiated training of nursing staff to included reporting skin issues, reporting undated dressings, correct process to conduct a body audit, and accurate documentation. No nursing staff members were allowed to work until trained.

The SA validated through interview and record review on 11/7/23, Director of Nursing (DON) and RCC/Infection Preventionist conducted 15 verification audits of documented body audits to ensure accuracy. No errors in accuracy of documentation were found.

The SA validated through interview and record review on 11/10/23 potential for skin problem care plans were reviewed on 76 residents with no changes made. Reviews conducted by MDS Nurse #1 and MDS Nurse #2.

The SA validated through interview and record review on 11/7/23 DON and RCC/Infection Preventionist conducted a visual evaluation of the feet of all residents who received podiatry services on 10/18/23 with no skin problems noted.

The SA validated through interview and record review the Quality Assurance Committee (QAC) recommendation of 11/7/23 implemented that all future Podiatry in-facility visits will be accompanied by a nurse for a minimum of two (2) months. Additional requirement made that Podiatry staff exit with DON, RCC/Infection Preventionist or RN Supervisor prior to leaving

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F 600	Continued From page 14 the facility at the end of each visit. The SA validated through interview and record review QAC meetings conducted on 11/7, 11/9 and 11/10/23 to review investigative steps and corrective actions taken. The SA validated through interview and record review on 11/11/23 and 11/12/23, body audits were conducted by the DON accompanied by the Administrator on seventy-five (75) residents. Body audits on all residents were completed by 11/14/23. The SA validated through interview and record review on 11/13/23 LPN #1 and LPN #2 were reported to the MS Board of Nursing. The SA validated through interview and record review on 11/15/23 training conducted at 2:30pm on reporting skin issues, reporting undated dressings, correct process to conduct a body audit, and accurate documentation presented by an Outside Facility Director of Nursing. No nursing staff will be allowed to work until they have been trained. The SA validated through interview and record review that an Emergency Quality Assurance committee meeting was conducted on 11/15/23 at 1:45 pm. Attending the meeting were the Administrator, DON, RCC/Infection Preventionist, Medical Director (via phone), Social Services, OT, MDS Nurse #1, and MDS Nurse #2.	F 600		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		12/7/23

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F 656	Continued From page 15 §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 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	F 656		

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F 656	Continued From page 16 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 interviews, record reviews, and facility policy reviews, the facility failed to implement comprehensive care plan interventions related to skin assessments for one (1) of four (4) sampled residents. Resident #1 The facility's failure to implement a care plan for weekly body audits and ensure the body audits were completed accurately resulted in Resident #1 sustaining an amputation of the fifth digit of her right foot and placed other residents in a situation that was likely to cause serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 10/18/23 when facility staff completed an inaccurate weekly body audit. The facility Administrator was notified of the IJ on 11/15/23 at 12:12 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 11/15/23, in which they alleged all corrective actions to remove the IJ were completed on 11/15/23, and the IJ removed on 11/16/23. The State Agency (SA) validated the Removal Plan on 11/16/23 and determined that the IJ was removed on 11/16/23, prior to exit. Therefore, the scope and severity for F656- Care Plans- was lowered from a "J" to a "D" while the	F 656	1. Resident #1 was sent to the Emergency Room on 11/7/23 and discharged from the facility on 11/9/23. 2. All Residents have the potential to be affected by the same deficient practice. 3. Nursing Staff were inserviced beginning on 11/15/23 by an outside facility Director of Nursing on reporting skin issues, reporting undated dressings, and the correct process to conduct a body audit, accurate documentation and following the careplan. All nursing staff will be inserviced by 11/22/23. A careplan audit was completed by the Minimum Data Set Nurses for all residents with potential for skin care problems on 11/16/23. All nursing staff that conducts body audits will complete skill check off with DON, RCC, and Staff Development nurse by 12/1/2023 to include detailed review of all parts of the body. . 4. Care plans for residents with skin evaluation will be reviewed by DON, Resident care coordinator Monday □ Friday x12 weeks to ensure the weekly skin evaluation are being completed as outlined on the care plan, beginning 11/16/23. Resident Care Coordinator, and Minimum Data Set Nurses will ensure care plan interventions are implemented. All audits will be reviewed by the Quality Assurance and Assessment Committee x	

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F 656	Continued From page 17 facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. 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 notified of their roles and responsibilities for carrying out the interventions ..." Record review of the Comprehensive Care Plan with an initiation date of 9/13/22, revealed "Focus: The resident has potential impairment to skin integrity r/t (related to) chronic illness, dementia, and edema ...Interventions : Weekly skin evaluation and nursing summary every Wednesday, Revision on 9/15/2022..." Record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/9/22 with diagnoses including Psychotic Disturbance, Mood Disturbance, Anxiety, Hypertension, and Autonomic Neuropathy. Record review of the " ...Skin Only Evaluation", dated 10/25/23, revealed License Practical Nurse (LPN) #1 documented that Resident #1 did not have current skin issues.	F 656	3 months beginning 12/6/23 to ensure sustained compliance.	

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In a phone interview on 11/14/23 at 2:00 PM, LPN #1 stated she incorrectly performed the skin/body audit on Resident #1 on 10/25/23. LPN #1 also confirmed she failed to follow the care plan for Resident #1, performing her body audit incorrectly.

Record review of the " ...Skin Only Evaluation", dated 10/18/23 and 11/1/23, revealed LPN #2 documented that Resident #1 did not have current skin issues.

During a phone interview on 11/14/23 at 2:30 PM, LPN #2 confirmed that she performed the skin/body audits on Resident #1 on 10/18/23 and 11/1/23 incorrectly by not performing them herself. LPN #2 also stated that she did not implement the care plan correctly on Resident #1 by not performing the skin audits correctly.

On 11/14/23 at 3:56 PM with the Director of Nurses (DON), she confirmed the facility staff failed to follow the care plan by not assessing or accurately performing head-to-toe body audits on Resident #1.

On 11/15/23 at 10:16 AM, an interview with Minimum Data Set (MDS) Nurse #2 confirmed that staff should follow the care plans for residents' dignity, integrity, and safety. She reported that care plans were developed individualized to ensure consistency in the nursing care of the resident, which helps improve services. She added that she expects all nursing staff in the facility to follow care plans for the residents.

The facility submitted the following acceptable

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Removal Plan on 11/15/23:

On 11/15/23 at 12:12pm, the State Survey Agency notified the Administrator that the facility 1.) neglected to provide accurate body audits and services to Resident #1 from 10/18/23 until 11/7/23, as evidenced by staff admission of incomplete body audits, resulted in Resident #1 sustaining an amputation of the fifth digit of her right foot. 2.) failed to implement care plan interventions for Resident #1 when the facility failed to provide complete and accurate weekly body audits from 10/18/23 through 11/7/23.

The Immediate Jeopardy Templates for F600 and F656 were provided to the Administrator on 11/15/23, at 12:12pm.

At approximately 12:00pm on 11/7/23, Occupational Therapist (OT) notified Registered Nurse #1 that Resident was experiencing discomfort of a toe on her right foot. RN #1 and Resident Care Coordinator/Infection Preventionist (RCC/Infection Preventionist) removed a pink bandage from the toe and requested that Nurse Practitioner evaluate Resident. Nurse Practitioner noted the right fifth toe to be necrotic at the nail bed, with plantar surface to have red and purple discoloration proceeding down the toe. Nurse Practitioner sent the Resident to the hospital for further evaluation and treatment. Resident was admitted to hospital 11/7/23, underwent surgery for toe amputation related to infection on 11/8/23, and discharged from the facility per family request on 11/9/23.

On 11/7/23, the facility initiated an investigation. The type of pink dressing found on Resident's foot is not a type purchased or used by the

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facility. Podiatry Nurse Practitioner saw Resident on 10/18/23. Interview revealed Podiatry Nurse Practitioner did use this type of pink dressing and stated to facility staff that she did use this type dressing on Resident. Her visit documentation did not indicate a dressing was applied.

Body audits conducted on 10/18/23 and 11/1/23 by LPN #1 did not indicate dressing present. Body audits conducted on 10/25/23 by LPN #2 (Agency) did not indicate dressing present. Due to inaccurate assessments, employment of LPN #1 was ended on 11/7/23 and the agency notified on 11/7/23 that LPN#2 (Agency) would not be allowed to work in the facility again.

On 11/7/23, Staff Development Nurse initiated training of nursing staff to include reporting skin issues, reporting undated dressings, correct process to conduct a body audit, and accurate documentation. No nursing staff members were allowed to work until trained.

On 11/7/23, Director of Nursing (DON) and RCC/Infection Preventionist conducted 15 verification audits of documented body audits to ensure accuracy. No errors in accuracy of documentation were found.

On 11/10/23, potential for skin problem care plans were reviewed on 76 residents with no changes made. Reviews conducted by MDS Nurse #1 and MDS Nurse #2.

On 11/7/23 DON and RCC/Infection Preventionist conducted a visual evaluation of the feet of all residents who received podiatry services on 10/18/23 with no skin problems noted. These were conducted due to interview with Podiatry

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Nurse Practitioner in which she stated she was uncertain of which residents she may have left bandages on.

Quality Assurance Committee (QAC) recommendation of 11/7/23 implemented that all future Podiatry in-facility visits will be accompanied by a nurse for a minimum of two (2) months. Additional requirement made that Podiatry staff exit with DON, RCC/Infection Preventionist or RN Supervisor prior to leaving the facility at the end of each visit.

QAC meetings conducted on 11/7, 11/9 and 11/10/23 to review investigative steps and corrective actions taken.

On 11/11/23 and 11/12/23, body audits were conducted by the DON accompanied by the Administrator on seventy-five (75) residents. Body audits on all residents were completed by 11/14/23.

On 11/13/23 LPN #1 and LPN #2 were reported to the Mississippi (MS) Board of Nursing.

On 11/15/23 training conducted at 2:30pm on reporting skin issues, reporting undated dressings, correct process to conduct a body audit, and accurate documentation presented by an Outside Facility Director of Nursing. No nursing staff will be allowed to work until they have been trained.

Emergency Quality Assurance committee meeting was conducted 11/15/23 at 1:45pm. Attending the meeting were Administrator, DON, RCC/Infection Preventionist, Medical Director (via phone), Social Services, OT, MDS Nurse #1 and

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MDS Nurse #2. Discussed in the meeting were: Recap of incident and investigation involving Resident #1, which had been reviewed in QAC meetings on 11/7, 11/9, and 11/10, Corrective actions taken, and Review of policies related to neglect, skin audits and care plans.

The facility implemented all corrective measure on 11/15/23 and alleges the immediate jeopardy was removed 11/16/23.

The SA validated the removal plan on 11/16/23 and immediacy removed on 11/16/23 prior to exit.

The State Agency (SA) validated the facility's removal plan on 11/16/23.

The SA validated through interview and record review that at approximately 12:00pm on 11/7/23, Occupational Therapist (OT) notified Registered Nurse #1 that Resident was experiencing discomfort of a toe on her right foot. RN #1 and Resident Care Coordinator/Infection Preventionist (RCC/Infection Preventionist) removed a pink bandage from the toe and requested that Nurse Practitioner evaluate Resident. Nurse Practitioner noted the right fifth toe to be necrotic at the nail bed, with plantar surface to have red and purple discoloration proceeding down the toe. Nurse Practitioner sent the Resident to the hospital for further evaluation and treatment. Resident was admitted to hospital 11/7/23, underwent surgery for toe amputation related to infection on 11/8/23, and discharged from the facility per family request on 11/9/23.

The SA validated through interview and record review that on 11/7/23, the facility initiated an investigation. The type of pink dressing found on

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Resident's foot is not a type purchased or used by the facility. Podiatry Nurse Practitioner saw Resident on 10/18/23. Interview revealed Podiatry Nurse Practitioner did use this type of pink dressing and stated to facility staff that she did use this type dressing on Resident. Her visit documentation did not indicate a dressing was applied.

The SA validated through interview and record review that body audits were conducted on 10/18/23 and 11/1/23 by LPN #1 did not indicate dressing present. Body audits conducted on 10/25/23 by LPN #2 (Agency) did not indicate dressing present. Due to inaccurate assessments, employment of LPN #1 was ended on 11/7/23 and the agency notified on 11/7/23 that LPN#2 (Agency) would not be allowed to work in the facility again.

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The SA validated through interview and record review on 11/7/23, Director of Nursing (DON) and RCC/Infection Preventionist conducted 15 verification audits of documented body audits to ensure accuracy. No errors in accuracy of documentation were found.

The SA validated through interview and record review on 11/10/23 potential for skin problem care plans were reviewed on 76 residents with no changes made. Reviews conducted by MDS

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Nurse #1 and MDS Nurse #2.

The SA validated through interview and record review on 11/7/23 DON and RCC/Infection Preventionist conducted a visual evaluation of the feet of all residents who received podiatry services on 10/18/23 with no skin problems noted.

The SA validated through interview and record review the Quality Assurance Committee (QAC) recommendation of 11/7/23 implemented that all future Podiatry in-facility visits will be accompanied by a nurse for a minimum of two (2) months. Additional requirement made that Podiatry staff exit with DON, RCC/Infection Preventionist or RN Supervisor prior to leaving the facility at the end of each visit.

The SA validated through interview and record review QAC meetings conducted on 11/7, 11/9 and 11/10/23 to review investigative steps and corrective actions taken.

The SA validated through interview and record review on 11/11/23 and 11/12/23, body audits were conducted by the DON accompanied by the Administrator on seventy-five (75) residents. Body audits on all residents were completed by 11/14/23.

The SA validated through interview and record review on 11/13/23 LPN #1 and LPN #2 were reported to the Mississippi (MS) Board of Nursing.

The SA validated through interview and record review on 11/15/23 training conducted at 2:30pm on reporting skin issues, reporting undated

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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 656	Continued From page 25 dressings, correct process to conduct a body audit, and accurate documentation presented by an Outside Facility Director of Nursing. No nursing staff will be allowed to work until they have been trained. The SA validated through interview and record review that an Emergency Quality Assurance committee meeting was conducted on 11/15/23 at 1:45 pm. Attending the meeting were the Administrator, DON, RCC/Infection Preventionist, Medical Director (via phone), Social Services, OT, MDS Nurse #1, and MDS Nurse #2.	F 656		