STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	Initial Comments The State Agency (SA) conducted three (3) Complaint Investigations (CI MS #23610, CI MS #23770, and CI MS #23771), at the facility from 2/5/24 through 2/8/24. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #23610 was investigated related to resident rights and CI MS #23770 was investigated related to dietary, facility staffing, residents left wet, and sufficient supplies, and there were no citations regarding these two (2) CIs. CI MS #23771 was investigated related to neglect and M500 and M640 were cited. Based on the facility's implementation of corrective actions on 11/2/23, the State Agency (SA) determined the deficiencies to be Past Non-Compliance (PNC), and the facility was in compliance as of 11/3/23, prior to the SA's entrance on 2/5/24.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for	M 500		3/4/24

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M 500	Continued From page 1 services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule,	M 500		

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M 500	Continued From page 2 regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;	M 500		

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M 500	Continued From page 3 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available	M 500		

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M 500	Continued From page 4 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on interviews, record review, and facility policy review, the facility failed to protect the resident's right to be free from neglect as evidenced by Resident #1, who was observed to have bruising, edema, and pain to her left thigh and vaginal area, did not receive care or treatment until the following day when she was diagnosed with a femoral fracture for one (1) of six (6) sampled residents. Resident #1. Findings included: A review of the facility's policy, "Abuse Prevention Program", reviewed July 2019, revealed, " Policy Statement: Our residents have the right to be free from abuse, neglect..." A review of the facility's policy, "Compliance with Reporting Allegation of Abuse/Neglect/Exploitation", dated 10/10/22, revealed, " ...Compliance Guidelines ...Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ..." A record review of the facility's investigation which included the,"Alleged Abuse Incident Report" dated 11/3/23, revealed that on 10/28/23 at approximately 1:45 PM, License Practical Nurse (LPN) #1 reported to Registered Nurse (RN) #2	M 500	No POC Required Citation is Past Non-Compliance	

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M 500	Continued From page 5 Supervisor that Resident #1 had bruising to the left thigh and vaginal area with swelling and pain. On 10/29/23 at approximately 7:30 AM, the assigned RN/Supervisor #1 observed Resident #1 bruising to the left thigh and groin area, with swelling and pain, notified her physician, and transferred Resident #1 to the local emergency room. Record review of a handwritten statement from Certified Nursing Assistant (CNA) #1, dated 10/29/23, revealed on 10/28/23 at about 1:30 PM, that CNA #1 noticed a large bruise on Resident #1's vagina and she informed LPN #1. CNA #1 and LPN #1 discovered another bruise on the bottom of her labia. A record review of the "Progress Notes" revealed a "Nurses Note", dated 10/28/23 at 1:45 PM, signed by LPN #1, revealed, "alerted to resident's room. upon exam bruising was noted to vaginal area, and left thigh. painful to touch. Swelling noted to upper left thigh. shift supervisor notified of resident's condition ..." Record review of a handwritten statement from LPN #1, undated, revealed on 10/28/23 at approximately 1:30 PM, he was called to Resident #1's room and was made aware of bruising to the groin/perineal care. There was old bruising noted to the vagina/major labia and inner left thigh. The resident was showing no signs or symptoms of distress or pain at this time. Shift supervisor was notified of the resident's condition. Report on resident's condition was given at shift change. On the following morning, 10/29/23, it was noted that the resident's left leg was visually displaced and that she was complaining of pain with movement.	M 500		

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M 500	Continued From page 6 A record review of a handwritten statement from RN #2, dated 10/30/23, revealed LPN #1 told her that the CNA said Resident #1 had an injury and he was going to write a report. The resident had a bruise and hematoma that they noticed on Saturday afternoon (10/28/23) and RN #2 did not go down and look at it. A record view of the "Progress Notes" revealed a "Nurses Note", dated 10/29/23 at 8:21 AM, signed by RN #1, revealed, "Alerted by (Proper Name) LPN #1 about bruising on resident's vagina and left hip. While putting resident's head of bed down to view the area, the resident began to cry out in pain. (Proper Name) Director of Nursing (DON) notified of situation. Dr. (Proper Name) aware. New orders given to send to ER for further evaluation." A record review of the hospital records,including the History and Physical and Progress notes, with an admission date of 10/29/23, revealed Resident #1 presented to the hospital with a left leg injury. Emergency Department (ED) workup was significant for left proximal femur fracture. The Physical Exam revealed Resident #1 had diffuse bruising at various stages of healing to left lower extremity and expected tenderness to left lower extremity. Patient withdraws to pain. The Assessment/Plan revealed the ED nursing staff filed an elder abuse report and pain medications were ordered. On 2/6/24 at 11:17 AM, during a phone conversation with LPN #1, he confirmed that on 10/28/23, around 1:00 PM, he was called to Resident #1's room by Certified Nurse Assistant (CNA) #1 and was made aware of the residents bruising of the left groin and vaginal area. He stated Resident #1 was non-verbal, had facial	M 500		

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grimacing, and was in pain. LPN #1 notified RN #2, who was the facility supervisor of Resident #1's bruising, and she informed him to complete an incident report. LPN #1 confirmed that he did not follow up with RN #2 to ensure the resident was assessed by the RN on 10/28/23. On 10/29/23 at approximately 7:00 AM, LPN #1 reported the bruising to RN #1. RN #1 assessed the resident and immediately called the Medical Director, the Director of Nursing (DON), and the ambulance for transfer to the hospital. LPN #1 confirmed that he should have provided more care to Resident #1 on 10/28/23 but was following the "chain of command."

On 2/6/23 at 11:27 AM, during a phone conversation with RN #2, she confirmed that on 10/28/23 after lunch, LPN #1 informed her of Resident #1 bruising to the left groin area. RN #2 confirmed she did not assess the resident. She passed the situation off to the night shift but could not remember the nurse's name. RN #2 stated it was the facility's policy to report bruising of the vaginal area to the DON and Medical Director and that she did not report or assess the resident.

On 2/6/24 at 11:35 AM, during a phone interview with CNA #1, she stated on 10/28/23 at approximately 1:30 PM, when changing Resident #1's brief, she observed a large orange and black bruise between her legs and groin area on the left side. The resident's leg was "cocked out a little," which was not normal for the resident because she normally kept her legs closed together very tight. She stated that she notified LPN #1.

On 2/6/24 at 11:41 AM, during a phone interview with RN #1, she confirmed on 10/29/23 at 7:24 AM, LPN #1 requested she assess Resident #1's peri-area related to bruising and swelling. She

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observed yellow and black bruising to her left groin and leg. RN #1 notified the DON, Medical Director, and called the local ambulance. The resident was transferred out of the facility by a local ambulance and brought to the local hospital.

On 2/7/24 at 10:11 AM, during an interview with the DON, she confirmed that on 10/29/23 at approximately 8:00 AM, she received a call from RN #1 stating that Resident #1 had bruising to her left hip, pubic area, and upper pelvic area. The DON stated that on 10/29/23 at approximately 12:20 PM, she entered the facility and began her investigation. However, she did not observe the resident or the bruising because the resident had already been transferred to the hospital. The DON revealed the facility did not follow the abuse and neglect policy because the RN should have assessed the resident and reported her findings to the Medical Director and the DON on 10/28/24 when the bruising was observed by facility staff.

On 2/7/24 at 2:49 PM, in an interview with the Administrator, he confirmed that on 10/28/23 the facility did not follow the abuse or neglect policy. He stated that Resident #1 should have been assessed by RN #2 on 10/28/23 and she should have reported the bruising to the Medical Director and the DON.

On 2/8/24 at 12:00 PM, during an interview with the Medical Director, he confirmed the facility did not contact him or provide him with any information on Resident #1's bruising of the left leg and perineal area on 10/28/23. He said he expected the facility to notify him of any change in a resident's condition.

Record review of the "Admission Record"

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revealed the facility admitted Resident #1 on 6/14/2016 and she had current diagnoses including Alzheimer's Disease and Vascular Dementia.

Record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date of 8/30/23, revealed Resident #1 required a staff interview for mental status and her cognition was severely impaired.

Based on the facility's implementation of corrective actions on 11/2/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC). The deficiency was corrected as of 11/3/23, before the SA's entrance on 2/5/24.

Validation:

On 2/8/23, the SA validated through staff interviews, record review, and facility policy review the facility began an investigation on 10/29/23.

The SA validated through staff interview and record review of the sign in sheet and meeting minutes that an emergency Quality Assurance Performance Improvement (QAPI) meeting with all required staff was held on 10/31/23 at 9:15 AM. The DON, Medical Provider, and Social Services Director attended the QAPI meeting to discuss the situation regarding abuse and neglect, including investigation and reporting of abuse and neglect. The QAPI members also discussed ethics and communication, perineal care, notification of changes, mechanical lift and transfer safety, care plans, and Kardex following the incident. The QAPI meeting concluded that the Plan of Correction was to in-service all staff,

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M 500	Continued From page 10 suspend the CNA, and conduct body audits on all residents. The QA Committee reviewed all related policies and procedures with no changes recommended. The SA validated through staff interview and record review of the in-service sign-in sheets that in-services with all staff conducted by the Administrator and the DON began on 10/29/23 regarding abuse and neglect, investigating and reporting abuse and neglect, ethics, communication, perineal care, notification of changes, mechanical lift and transfer safety, care plan, and Kardex. No staff were allowed to work until they received the in-service training. The SA validated through staff interview and record review that the DON conducted Resident mechanical lift/transfer assessments on all residents on 11/1/23 and ensured all were up-to-date and care planned accordingly. The SA validated through staff interview and record review that on 11/1/23 through 11/2/23, the DON completed new pain assessments for all residents and updated the care plan accordingly. The SA validated through staff interview and record review that the DON completed body audits on 10/29/23 through 10/31/23 on all current residents. The SA validated through staff interview and record review, for monitoring purposes, all nurses and CNAs completed a lift skill observation. The SA validated through staff interview and record review, for monitoring purposes, Transfer Audits were completed by the nurse two (2) times per day until 12/31/23.	M 500		

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M 500	Continued From page 11 The SA validated through staff interview and record review, for monitoring purposes, weekly body audits are completed by nurses on all residents. The SA validated that the facility reported the incident to the SA and the Attorney General Office (AGO) on 10/29/23.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on record reviews, interviews, and facility policy review, the facility failed to ensure a resident was free of accidents and/or hazards when a staff member transferred a resident using a mechanical lift without two (2) people to assist for one (1) of six (6) sampled residents. Resident #1. Findings include: Record review of the facility's "Safe Transfer and Lifting of Residents" policy, revised 8/2/22, revealed, " ...In order to protect the safety and well-being of ...residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents ...Policy	M 640	No POC Required Citation is Past Non-Compliance	3/4/24

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M 640	Continued From page 12 Interpretation and Implementation ...VI. Procedure for transferring resident with full body lift ...f. Ensure 2nd person is assisting ..." A record review of the facility's investigation which included the,"Alleged Abuse Incident Report" dated 11/3/23, revealed that on 10/28/23 at approximately 1:45 PM, License Practical Nurse (LPN) #1 reported to Registered Nurse (RN) #2 Supervisor that Resident #1 had bruising to the left thigh and vaginal area with swelling and pain. On 10/29/23 at approximately 7:30 AM, the assigned RN/Supervisor #1 observed Resident #1 bruising to the left thigh and groin area, with swelling and pain, notified her physician, and transferred Resident #1 to the local emergency room. The investigation revealed during camera review, 10/28/23 at 6:42 AM, Certified Nursing Assistant (CNA) #2 pushed Resident #1 out of her room in a Geri-chair and her left leg was not crossed over her right as per her normal routine. A record review of the "Progress Notes" revealed a "Nurses Note", dated 10/28/23 at 1:45 PM, signed by LPN #1, revealed, "alerted to resident's room. upon exam bruising was noted to vaginal area, and left thigh. painful to touch. Swelling noted to upper left thigh. shift supervisor notified of resident's condition ..." Record review of a handwritten statement from LPN #1, undated, revealed on 10/28/23 at approximately 1:30 PM, he was called to Resident #1's room and was made aware of bruising to the groin/perineal care. There was old bruising noted to the vagina/major labia and inner left thigh. The resident was showing no signs or symptoms of distress or pain at this time. Shift supervisor was notified of the resident's condition. Report on resident's condition was given at shift	M 640		

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BEDFORD CARE CENTER OF PICAYUNE	2797 COOPER ROAD PICAYUNE, MS 39466

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change. On the following morning, 10/29/23, it was noted that the resident's left leg was visually displaced and that she was complaining of pain with movement.

A record review of a handwritten statement from RN #2, dated 10/30/23, revealed LPN #1 told her that the CNA said Resident #1 had an injury and he was going to write a report. The resident had a bruise and hematoma that they noticed on Saturday afternoon (10/28/23) and RN #2 did not go down and look at it.

A record view of the "Progress Notes" revealed a "Nurses Note", dated 10/29/23 at 8:21 AM, signed by RN #1, revealed, "Alerted by (Proper Name) LPN #1 about bruising on resident's vagina and left hip. While putting resident's head of bed down to view the area, the resident began to cry out in pain. (Proper Name) Director of Nurses(DON) notified of situation. Dr. (Proper Name) aware. New orders given to send to ER for further evaluation."

A record review of the hospital records including the History and Physical and Progress Notes, with an admission date of 10/29/23, revealed Resident #1 presented to the hospital with a left leg injury. Emergency Department (ED) workup was significant for left proximal femur fracture. The Physical Exam revealed Resident #1 had diffuse bruising at various stages of healing to left lower extremity and expected tenderness to left lower extremity. The Assessment/Plan revealed the ED nursing staff filed an elder abuse report and pain medications were ordered.

Record review of the "Employee Termination Report", dated 11/3/23, revealed CNA #2 was discharged from employment with the facility due

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M 640	Continued From page 14 to "Violation of Lift Policy". On 2/6/24 at 11:17 AM, during a phone interview with LPN #1, he confirmed that on 10/28/23, around 1:00 PM, he was called to Resident #1's room by Certified Nurse Assistant (CNA) #1 and was made aware of the residents bruising of the left groin and vaginal area. He stated Resident #1 was non-verbal, had facial grimacing, and was in pain. LPN #1 notified RN #2, who was the facility supervisor, of Resident #1's bruising, and she informed him to complete an incident report. On 2/6/24 at 11:35 AM, during a phone interview with CNA #1, she stated on 10/28/23 at approximately 1:30 PM, when changing Resident #1's brief, she observed a large orange and black bruise between her legs and groin area on the left side. The resident's leg was "cocked out a little," which was not normal for the resident because she normally kept her legs closed together very tight. She stated that she notified LPN #1. On 2/6/24 at 11:41 AM, during a phone interview with RN #1, she confirmed on 10/29/23 at 7:24 AM, LPN #1 requested she assess Resident #1's peri-area related to bruising and swelling. She observed yellow and black bruising to her left groin and leg. RN #1 notified the DON, Medical Director, and called the local ambulance. The resident was transferred out of the facility by a local ambulance and brought to the local hospital. On 2/7/24 at 10:11 AM, during an interview with the DON, she confirmed that on 10/28/23, Resident #1 had bruising of her left groin and peri-area with leg swelling. The DON stated the injury that Resident #1 sustained could have been caused by a CNA performing a transfer with mechanical lift by herself with no other staff	M 640		

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assistance. The DON revealed that according to the video surveillance, CNA #2 entered and exited the resident's room alone, with the mechanical lift. The CNA was placed on suspension and terminated following the investigation.

On 2/7/24 at 2:49 PM, in an interview with the Administrator, he confirmed he observed the video surveillance, and on 10/28/23, CNA #2 entered Resident #1's room at approximately 6:00 AM alone with the mechanical lift. CNA #2 exited about 15 minutes later with Resident #1. The Administrator stated the facility could not determine the exact cause of the injury following the investigation but that it was likely caused by the night shift CNA on 10/28/23. CNA #2 was suspended pending investigation and then terminated.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/14/2016 and she had current diagnoses including Alzheimer's Disease and Vascular Dementia.

Record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date of 8/30/23, revealed Resident #1 required a staff interview for mental status and her cognition was severely impaired.

Based on the facility's implementation of corrective actions on 11/2/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC). The deficiency was corrected as of 11/3/23, before the SA's entrance on 2/5/24.

Validation:

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M 640	Continued From page 16 On 2/8/23, the SA validated through staff interviews, record review, and facility policy review the facility began an investigation on 10/29/23. The SA validated through staff interview and record review of the sign in sheet and meeting minutes that an emergency Quality Assurance Performance Improvement (QAPI) meeting with all required staff was held on 10/31/23 at 9:15 AM. The DON, Medical Provider, and Social Services Director attended the QAPI meeting to discuss the situation regarding abuse and neglect, including investigation and reporting of abuse and neglect. The QAPI members also discussed ethics and communication, perineal care, notification of changes, mechanical lift and transfer safety, care plans, and Kardex following the incident. The QAPI meeting concluded that the Plan of Correction was to in-service all staff, suspend the CNA, and conduct body audits on all residents. The QAPI Committee reviewed all related policies and procedures with no changes recommended. The SA validated through staff interview and record review of the in-service sign-in sheets that in-services with all staff conducted by the Administrator and the DON began on 10/29/23 regarding abuse and neglect, investigating and reporting abuse and neglect, ethics, communication, perineal care, notification of changes, mechanical lift and transfer safety, care plan, and Kardex. No staff were allowed to work until they received the in-service training. The SA validated through staff interview and record review that the DON conducted Resident mechanical lift/transfer assessments on all	M 640		

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M 640	Continued From page 17 residents on 11/1/23 and ensured all were up-to-date and care planned accordingly. The SA validated through staff interview and record review that on 11/1/23 through 11/2/23, the DON completed new pain assessments for all residents and updated the care plan accordingly. The SA validated through staff interview and record review that the DON completed body audits on 10/29/23 through 10/31/23 on all current residents. The SA validated through staff interview and record review, for monitoring purposes, all nurses and CNAs completed a lift skill observation. The SA validated through staff interview and record review, for monitoring purposes, Transfer Audits were completed by the nurse two (2) times per day until 12/31/23. The SA validated through staff interview and record review, for monitoring purposes, weekly body audits are completed by nurses on all residents. The SA validated that the facility reported the incident to the SA and the Attorney General Office (AGO) on 10/29/23.	M 640		