MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18CR	A. BUILDING: _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF HATTIES	#10 MEDICAL BOULEVARD HATTIESBURG, MS 39401

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a recertification survey from 08/13/18 to 08/16/18. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M615. The census at the time of entrance was 133, and the facility was certified for 152 beds.	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 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	M 500		10/9/18

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M 500	Continued From page 1 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, 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	M 500		

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure Resident #22's right to receive care to prevent a pressure ulcer, as evidenced by the	M 500	Disclaimer: Bedford Care Center of Hattiesburg, LLC acknowledges receipt of Statement of Deficiencies and proposes this plan of corrections to the extent that the summary of the findings is factually correct and in order to maintain compliance with	

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M 500	Continued From page 4 facility's failure to follow the comprehensive care plan related to pressure ulcers, for (1) one of 30 resident care plans reviewed. Findings include: Review of the facility's policy, titled, "Using the Care Plan", revised August 2006, revealed, the care plan shall be used in developing the resident's daily care routines, and will be available to staff personnel who have responsibility for providing care or services to the resident. Review of Resident #22's Care Plan revealed the Problem for the Potential for Altered Skin Integrity, with an original date of 05/29/18, and on 06/05/18 a Deep Tissue Injury (DTI) to the right heel, and on 07/22/18, a stage three (3) to the right heel. Interventions, dated 05/29/18, included pressure relieving mattress to the bed, and cushion to the chair, observe for new onset of skin complications/breakdown, weekly body audits, and provide treatment to the stage three (3) pressure injury to the right heel as ordered until healed. On 06/07/18, an intervention to apply heel protectors to bilateral feet and float heels while in bed was added. Further review of the Care Plan revealed the Problem for Requiring Assist with ADLs (Activities of Daily Living) due to left sided hemiplegia/involuntary tremors dated 05/29/18. The Interventions, dated 05/29/18, included extensive assist x 2 (times two) with bed mobility. Interventions, dated 08/09/18, included extensive assist x 1 (times one) with bathing, wheel chair mobility, and hygiene, and on 08/15/18, extensive assist x 2 (times two) with toileting. Review of Resident #22's Admission Minimum	M 500	applicable rules and regulations. Please accept this plan of correction as our allegation of compliance. Bedford Care Center of Hattiesburg, LLC response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. M500 * Resident # 22 was discharged on September 6, 2018, prior to the facility receiving the statement of deficiencies. ** Residents with Care Plans related to pressure ulcers and potential altered skin integrity may be affected by this alleged deficient practice. *** Beginning August 27, 2018, through September 11, 2018, the Staff Development Registered Nurse conducted in-services related to following care plans to promote skin integrity. On September 14, 2018, the Medications Administration Records (MAR) for residents with pressure ulcers and potential for altered skin integrity have been updated, by the Order Entry Nurse, to include documentation for heel protectors, flotation of heels and use of wedges. Beginning on September 12, 2018, the electronic health record for Certified Nursing Assistants' required documentation was modified by the facility's information technology contractor, to include mattress to bed, cushion to chair and new onset of skin complication or breakdown. Beginning on September	

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M 500	Continued From page 5 Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/18, revealed there were no pressure ulcers present, and Resident #22 was at risk for developing pressure ulcers. Review of Resident #22's 60 Day Scheduled Assessment MDS, with an ARD of 07/24/18, revealed the presence of a stage three (3) pressure ulcer On 8/14/18 at 12:05 PM, an observation revealed Registered Nurse (RN) #2, assisted by Certified Nursing Assistant (CNA) #5, provided wound care to Resident #22's right heel. Resident #22's right heel was noted to be pink with no drainage. On 8/15/18 at 12:15 PM, an interview with Registered Nurse (RN) #1 revealed she would expect staff to follow the resident's care plan. A review of the Admission Record revealed, Resident #22 was admitted by the facility, on 5/28/18, with a diagnosis of Cerebral Infarction. Review of Resident #22's Admission MDS, with an ARD of 06/04/18, revealed a Basic Interview for Mental Status (BIMS) score was 5, which indicated severe cognitive impairment	M 500	14, 2018, the Director of Nurses or the Resident Care Coordinators shall review the skin hygiene body check report for ten (10) residents per week for two weeks, then five (5) residents per week for two weeks and then three (3) residents per week for two weeks, to ensure that the comprehensive care plan is followed and that documentation is provided. **** The findings of the audits will be reported to the Quality Assurance Committee, monthly for three (3) months, by the Director of Nurses. The Quality Assurance committee will make recommendations as needed.	
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.	M 615		10/9/18

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M 615	Continued From page 6 This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent pressure ulcer development for (1) one of (6) six pressure ulcer observations, for Resident #22. Findings include: A review of the facility's policy titled, "Pressure Ulcer/Skin Breakdown-Clinical Protocol", revised April 2018, revealed the staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. On 8/14/18 at 12:05 PM, an observation revealed Registered Nurse (RN) #2, assisted by Certified Nursing Assistant (CNA) #5, provided wound care to Resident #22's right heel. Resident #22's right heel was noted to be pink with no drainage. Record review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/7/18, revealed a pressure ulcer stage three (3) coded in section M of the MDS. Review of the Admission MDS, with an ARD of 6/4/18, revealed section M was coded to show no pressure ulcers present. Review of the August 2018 Treatment Administration Record (TAR) revealed a treatment, with a start date of 07/22/18, for a stage three (3) pressure injury to the right heel, and to cleanse the pressure injury with Normal Saline (NS), pat dry, and apply Promogran to the wound bed once every three (3) days. Apply skin prep to the peri-wound area, and cover with a	M 615	M615 * Resident # 22 discharged from the facility on September 6, 2018, prior to the facility receiving the statement of deficiencies. ** Residents with potential for altered skin integrity may be affected by this alleged deficient practice. *** Beginning on August 27, 2018, through September 11, 2018, the Staff Development Registered Nurse conducted in-services with Licensed Nurse and Certified Nursing Assistants, related to promoting skin integrity. On September 14, 2018, the Medications Administration Records (MAR)for residents with pressure ulcers and potential for altered skin integrity have been updated to include documentation for heel protectors, flotation of heels and use of wedges, by the Order Entry Nurse. On September 12, 2018, the electronic health record for Certified Nursing Assistants' required documentation was modified by the facility's information technology contractor, to include mattress to bed, cushion to chair and new onset of skin complication or breakdown. Beginning on September 14, 2018, the Director of Nurses or the Resident Care Coordinators shall review the skin hygiene body check report for ten (10) residents per week for two weeks, then five (5) residents for per week two weeks and then three (3) residents per week for two weeks, to ensure the comprehensive care plan is being followed	

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M 615	Continued From page 7 border foam. Further review the TAR revealed the treatment changed, on 08/14/18, to cover the stage three (3) pressure injury to the right heel with a border foam dressing, and change every three (3) days and as needed (prn). Review of the August 2018 Physician Orders revealed an order, dated 08/14/18, to cover the stage three (3) pressure injury to the right heel with a border foam dressing, and change every three (3) days and as needed (prn). Further review of the Physician's Orders revealed an order, dated 08/14/18, to discontinue the pressure injury treatment to the right heel to cleanse the injury with NS, pat dry and apply Promogram On 8/15/18 at 11:15 AM, an interview, with the Director of Nurses (DON), revealed Resident #22 was admitted, and roughly about three (3) days later had a Deep Tissue Injury (DTI) that later opened. The DON stated everybody (referring to the nursing staff) knows the standard to float heels, and to turn residents while in bed. She also stated, if the area had been identified earlier on admission, for example, the staff would have been able to treat it earlier. A review of the facility's Record of Admission revealed Resident #22 was admitted by the facility, on 5/28/18. Review of the most recent MDS, with an ARD of 8/7/18, revealed a Brief Interview of Mental Status (BIMS) score of 8, indicating a moderately impaired cognitive status.	M 615	and documentation is being provided. Beginning on September 17, 2018, to ensure the accuracy of the initial admission or readmission body audit, the Resident Care Coordinator or the Registered Nurse Supervisor shall conduct additional body audits of fifty (50)% of residents admitted or readmitted each week for two weeks, then thirty (30)% of residents admitted or readmitted each week for two weeks and then ten (10)% of residents admitted or readmitted each week for two weeks. **** The findings of the audits will be reported to the Quality Assurance Committee, monthly for three (3) months, by the Director of Nurses. The Quality Assurance committee will make recommendations as needed.	