STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET 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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 03/25/2024 through 03/28/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F640 and F695. The facility had a census of 75 and was licensed for 80 beds.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		4/19/24

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

Electronically Signed | 04/08/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to transmit a Discharge Minimum Data Set (MDS) Assessment in a timely manner for one (1) of 19 residents reviewed for MDS assessments. (Resident # 58) Findings Include: Record review of the facility's policy, "Resident Assessment Instrument", revised 06/17/2022 revealed, " POLICY STATEMENT: A comprehensive assessment of a resident's needs shall be made ...periodically ...POLICY	F 640	Resident #58's Discharge Minimum Data Set was completed and transmitted on 3/28/24. All residents have the potential to be affected by the deficient practice. The Minimum Data Set (MDS) Nurses were trained on scheduling, completing and transmitting the MDS in a timely manner, by the Director of Nursing (DON) on 03/28/2024. An audit was completed by the MDS Nurses on 03/28/2024 to ensure that all required MDS□s have	

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F 640	Continued From page 2 INTERPRETATION AND IMPLEMENTATION: 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews ..." Record review of the "Admission Record" revealed the facility admitted Resident #58 on 10/31/23 and he had diagnoses including Atrial Fibrillation. Record review of a Physician's Order, dated 1/15/24, revealed Resident #1 was sent to a local Emergency Room (ER) for evaluation and treatment. Review of the medical record of Resident #1 revealed the MDS Discharge assessment was not transmitted when he was sent to the hospital on 1/15/24. During an interview on 03/27/24 at 9:47 AM, with Registered Nurse (RN) #1, he confirmed the facility failed to transmit the hospital discharge MDS for Resident #58 and confirmed the resident did not return to the facility. He reported the staff discussed in daily stand up about residents that are sent to the local hospital. RN #1 explained that it was his responsibility to transmit the hospital discharge within 14 days. He was unsure how it was missed because corporate also completed spot checks to ensure MDS were transmitted. During an interview on 3/28/24 at 10:04 AM, with the Director of Nurses (DON), she stated she expected the facility staff to transmit the hospital discharge MDS in a timely manner. She was unsure how the discharge transmittal was missed	F 640	been completed and transmitted as required. The DON will audit the MDS schedule weekly x 12 weeks beginning 3/29/2024 to ensure that all required MDS's have been scheduled, completed, and transmitted. Audits will be reviewed by the Quality Assessment and Assurance Committee monthly x 3 months beginning on 4/19/2024 to ensure sustained compliance.	

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F 640	Continued From page 3 because they have systems in place to ensure they are submitted.	F 640		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed ensure a nebulizer mask was stored in a designated storage bag one (1) of one (1) resident reviewed for respiratory care. Resident #179. Findings include: A record review of the facility's policy, "Administering Medications through a Small Volume (Handheld) Nebulizer", revised date 8/2/22, revealed, "The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway ... 23. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it ..." A record review of the "Order Summary Report", with active orders as of 03/27/24, revealed Resident #179 had a Physician's Order, dated 3/20/24, for "Ipratropium-Albuterol Solution	F 695	Resident #179's nebulizer mask was placed in a plastic bag and dated on 03/26/2024. All residents have the potential to be affected by the deficient practice. All nursing staff were trained on proper storage of respiratory tubing by the Staff Development Nurse on 04/10/2024. An audit of all residents with nebulizer treatments to ensure masks are stored correctly was completed by the Director of Nursing on 03/28/2024. The Registered Nurse (RN) Supervisor will use the RN Round Checklist 5 x week x 12 weeks beginning 4/1/2024 to ensure that all respiratory tubing is properly stored. The Checklists will be reviewed by the Quality Assessment and Assurance Committee monthly x 3 months beginning	4/19/24

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F 695	Continued From page 4 0.5-2.5 (3) mg (milligram)/ 3 ml (milliliters) 1 vial inhale orally four times a day for wheezing/sob (shortness of breath)". On 03/25/24 at 11:26 AM, during an observation, Resident #179 was lying in bed sleeping. A nebulizer mask was tied to the left bedrail and was not stored in a designated bag. At 12:39 PM on 03/25/24, during an observation and an interview with Licensed Practical Nurse (LPN) #1, she confirmed the nebulizer mask was tied directly onto the bedrail for Resident #179 and explained that the mask should have been stored in a plastic bag. LPN #1 was unable to find a designated storage bag in the room and stated she would get a bag to store the mask. LPN #1 reported that Resident #179 was not able to tie the mask to the bedrail and that a staff member must have placed it there. On 03/26/24 at 01:30 PM, during an interview with the Director of Nursing (DON), she explained all nebulizer masks should be stored in a clear bag, dated, and changed weekly with the oxygen tubing. She expected all nurses to follow the policy and store nebulizer masks in designated bags to prevent infections or complications. A record review of the "Admission Record" revealed the facility admitted Resident #179 on 03/20/20 with diagnoses including Alzheimer's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/07/24 revealed Resident #179 had a Brief Interview for Mental Status (BIMS) score of 02, which indicated his cognition was severely	F 695	on 4/19/2024 to ensure sustained compliance.	

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F 695	Continued From page 5 impaired.	F 695		