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
	MS55BCCP	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PICAYUNE	2797 COOPER ROAD PICAYUNE, MS 39466

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 05/20/2024 through 05/23/2024. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500, M655, M815 and M1570.	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 participate in the planning of his medical	M 500		7/10/24

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M 500	Continued From page 1 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 responsibility to the facility for any period of time	M 500		

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M 500	Continued From page 2 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 documented by his physician or nurse	M 500		

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M 500	Continued From page 3 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 record review, staff interview, and facility policy review, the facility failed to ensure an advance directive, specifically a durable Power of Attorney (POA), was available and readily retrievable by facility staff for one (1) of 32 residents reviewed for advance directives.	M 500	1. The Power of Attorney for resident #100 was uploaded into the clinical record. A new Acknowledgement of Advance Directive form was signed to reflect resident has a POA, not a living will, and was scanned into the chart on 6/12/24. 2. All residents have the potential to be affected by the deficient practice.	

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M 500	Continued From page 4 (Resident #100). This deficient practice had the potential to affect all residents who had a durable POA. Findings Include: A review of the facility's policy, "Residents' Rights Regarding Treatment and Advanced Directives", revised 11/1/22, revealed, "Policy: It is the policy of this facility to support and facilitate a resident's right to ...formulate an advance directive. Definitions: "Advance Directive" is a written instruction, such as a... durable power of attorney for health care...Policy Explanation and Compliance Guidelines...3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart..." Record review of the "Acknowledgement of Advance Directives Decisions, Rights, and Information", signed 2/9/24, which was located in the electronic health record and signed by the Resident Representative (RR), indicated Resident #100 had a "Living Will". Upon review of the medical record, there was no copy of an advance directive or POA located in the medical chart. On 5/20/24 at 1:15 PM, in an interview and record review with Registered Nurse (RN) #1, she stated advance directives are in the resident's electronic chart and reviewed the electronic health record for Resident #100. She acknowledged there was no advance directive located under the "Misc" (Miscellaneous) tab of the electronic chart. She confirmed there were no paper charts or other areas of the nurse's station where advance directives would be kept. She commented that if a resident had an advance directive, she thought it would be listed under the "Special Instructions"	M 500	3. All residents "Acknowledgement of Advance Directives" documents have been reviewed by Social Services department to ensure that the forms are accurate and current as of 6/12/24. 4. The "Acknowledgement of Advance Directives" documents completed for all new admissions will be audited weekly for 12 weeks by the Resident Care Coordinators starting 6/7/24 to ensure that the items marked as being present have been uploaded into the clinical record. All audits will be reviewed by the Quality Assurance and Assessment Committee monthly for 3 months beginning 7/9/24 to ensure sustained compliance.	

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M 500	Continued From page 5 which was readily viewable by all staff. She confirmed there were no instructions listed on the "special instructions" section for Resident #100. On 5/20/24 at 1:45 PM, in an interview with the Director of Nursing (DON), she revealed Resident #100 did not have a living will but clarified the RR had provided a POA to the facility and he had incorrectly checked the "Living Will" while electronically signing the admission paperwork. The DON explained the POA could be viewed on the "Administration Side" of the electronic health record and not the "Clinical Side", which meant the POA could not be viewed by nurses or clinical staff. The DON provided a paper copy of Resident #100's POA and advised she would have the POA scanned into the "Misc" tab on the electronic medical record. On 5/20/24 at 1:56 PM, in an interview with the Admission Coordinator, she explained she was responsible for discussing advance directives with residents and the RR upon admission to the facility. She stated if a resident had a POA, she kept a copy in a binder. She further explained the binder was in an office that was locked after hours and on weekends, and was located in Building 2, which was a separate building from Building 1. The Admissions Coordinator confirmed POAs were not readily retrievable by facility staff. A record review of the "Admission Record" revealed the facility admitted Resident #100 on 2/22/24 and she had current diagnoses including Hemiplegia and Hemiparesis.	M 500		
M 655	45.21.11 Special needs	M 655		7/10/24

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M 655	Continued From page 6 Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and record review, the facility failed to store an O2 (Oxygen) nasal cannula and a nebulizer mask in a designated container and failed to change or discard a disposable humidifier water bottle timely for one (1) of two (2) residents reviewed for oxygen therapy. Resident #3 Findings include: Record review of the facility's policy, "Oxygen Administration", revised 8/2/22, revealed "Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration..." However, the policy did not address O2 and Nebulizer tubing storage or changing the disposable water humidifier bottle. On 5/20/24 at 9:13 AM, Resident #3 was observed sleeping in bed. She was not wearing oxygen and there was an O2 concentrator located next to the bed and bedside table. There was a nasal cannula tubing wrapped around the concentrator and not stored in a bag. The disposable humidifier water bottle attached to the concentrator had a handwritten date of "12/21/23", was half full, and was attached to a nasal cannula tubing that was dated 5/16/24.	M 655	1. Resident #3 nasal cannula was placed in a plastic bag and dated on 5/21/24. The expired humidifier water bottle was disposed of, and was replaced with a humidifier water bottle that was not expired, the bottle was also dated 5/21/24. Resident #3 was not using oxygen at any point during the last 6 months from the survey date. She was assessed on 5/21/24 by Registered Nurse and was not affected in any way because of the lack of need for the oxygen that was in her room. 2. All residents that receive oxygen have the potential to be affected by the deficient practice. 3. All nursing staff were trained on proper storage of respiratory tubing and disposing of expired humidifier water bottles by the Staff Development Nurse on 6/7/24, 6/10/24, 6/11/24, 6/12/24. An audit of all residents with oxygen tubing and humidifier water bottles was completed by the Resident Care Coordinator and central supply coordinator on 6/6/24. 4. The Registered Nurse (RN) Supervisor will use the RN Supervisor Daily Round Checklist 4x a week x 12 weeks beginning 6/10/24 to ensure all respiratory tubing is properly stored. The Checklists will be reviewed by the Quality Assurance and	

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M 655	Continued From page 7 There was a nebulizer machine on the bedside table and the mask was hanging down the side of the bedside table and not stored in a designated bag or container. A record review of the "Admission Record" revealed the facility admitted Resident #3 on 1/6/22 and she had current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the "Order Summary Report", with active orders as of 5/21/24, revealed Resident #3 had a Physician's Order, dated 3/20/24, for "O2 (Oxygen) at 2L/min (liters per minute), TITRATE TO KEEP O2 SATS (Saturation) > 92%" and a Physician's Order, dated 11/20/23 for "Ipratropium-Albuterol Solution 0.5-2.5 ...1 vial inhale orally every 12 hours as needed ..." On 5/21/24 at 2:10 PM, an interview with Licensed Practical Nurse (LPN) #2 revealed Resident #3 was not currently using oxygen because it was ordered as needed and LPN #2 stated the resident had not needed to wear it recently. He stated that he did not look at the oxygen water humidifier bottle or how the tubing was stored because the night shift staff were responsible for changing those out weekly. On 5/21/24 at 2:30 PM, in an interview and observation in Resident #3's room with Registered Nurse (RN) #5, she confirmed the O2 nasal cannula and nebulizer mask were not stored in a designated container and stated they should have been stored in a bag. She also verified the O2 concentrator water humidifier bottle was dated 12/21/23 and thought it should be changed weekly.	M 655	Assessment Committee every month for 3 months beginning 7/9/24 to ensure sustained compliance.	

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M 655	Continued From page 8 On 5/22/24 at 10:30 AM, in an interview with the Director of Nursing (DON), she stated she expected oxygen nasal cannula tubing and nebulizer masks to be stored appropriately and for staff to change or discard oxygen humidifier bottles timely.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, and facility policy review, the facility failed to discard expired foods and failed to label opened foods with a use-by date for one (1) of three (3) kitchen observations. Findings include: A review of the facility's policy, "Food Safety Requirements", revised 11/21/22, revealed, " ...Food will be stored ...in accordance with professional standards for food safety ...Policy Interpretation and Implementation ...1. Food safety will be followed throughout the facility's entire food handling process ...b. Storage of food in a manner that helps prevent deterioration or contamination of the food ...3. Facility will inspect all food ...and ensure timely and proper storage ...c. Refrigerated storage ...Practices to maintain safe refrigerated storage include ...iv. labeling, dating, and monitoring refrigerated food ..."	M 815	1. The expired food items and the food items with no opened or use-by dates were discarded immediately by the respective dietary managers. No residents were affected by this alleged deficient practice. 2. All residents who eat by mouth have the potential to be affected by this alleged deficient practice. 3. All food and nutrition staff were in-serviced regarding the facility policy for Food Safety Requirements and Food Receiving and Storage by 6/13/24. Dietary Managers audited for expired food items and items with no opened and/or use by dates on 6/9/24 and 6/12/24. 4. The Dietary Managers will complete audits twice weekly for 12 weeks to check for expired food items and items with no opened and/or use by dates. Audits will be reviewed monthly for 3 months by the Quality Assurance and Assessment Committee to ensure sustained	7/10/24

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M 815	Continued From page 9 On 05/20/24 at 8:00 AM, during the initial tour of the kitchen with the Dietary Manager (DM) #1 of Building 1, revealed an opened gallon of buttermilk in the "Cook's Refrigerator" with a manufacturer's expiration date of 12/2023. DM #1 confirmed the buttermilk was expired. On 05/20/24 at 8:00 AM, during the initial tour of the kitchen with DM #2, the walk-in refrigerator had clear containers of olives that did not have an opened or use-by date and an opened container of sour cream with no opened or use-by date. DM #2 confirmed the containers of olives and sour cream did not have a use-by date. On 05/21/24 at 10:12 AM, in an interview with DM #1 and DM #2, they stated it was everyone's responsibility to ensure opened foods were labeled with a use-by date and expired foods were discarded, but it was ultimately their responsibility to oversee that it was done.	M 815	complaince.	
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a	M1570		7/10/24

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M1570	Continued From page 10 mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to provide hand hygiene for residents prior to meals for one (1) of four (4) dining rooms observed. Dining Room C. Findings include: A record review of the facility's policy, "Handwashing/Hand Hygiene" revised 8/2/22, revealed, " ...This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation ...5. Residents ...will be encouraged to practice hand hygiene ...7. Use an alcohol-based hand rub ...or...soap ...and water for the following situations ...o. Before and after eating or handling food ..." On 5/20/24 at 10:51 AM, during an observation of Dining Room C, the facility staff did not offer to assist residents with washing or sanitizing their hands. There were four (4) Certified Nurse Aides (CNAs) and one (1) Licensed Practical Nurse (LPN) present.	M1570	1. Hand sanitizer was placed in each dining room, as well as wet wipes. Nursing staff that were working on 5/20/24 were immediately educated during the lunch time meal to make them aware of the importance of hand hygiene for residents before meals. 2. All residents have the potential to be affected by this deficient practice. 3. All nursing staff will be inserviced on resident's hand hygiene before meals by the Staff Development Nurse by 6/12/24. 4. The Staff Development Nurse and Resident Care Coordinators will observe dining room and complete dining room observation 3 times a week for 12 weeks beginning 6/12/24 to ensure compliance with hand hygiene. Audits will be reviewed by the Quality Assurance and Assessment Committee monthly for 3 months beginning 7/9/24 to ensure sustained compliance.	

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M1570	Continued From page 11 On 5/20/24 at 11:44 AM, during an observation, three (3) residents were assisted to the dining room table in Dining Room C by therapy staff. The residents were not offered assistance with washing or sanitizing their hands prior to the meal being served. On 5/20/24 at 11:48 AM, during an interview with the Director of Nursing (DON), she was in Dining Room C and observed the three (3) residents who came from therapy to the dining room table and staff did not offer assistance with washing or sanitizing their hands. The DON explained CNAs were responsible for assisting the residents with hand hygiene before meals. On 05/20/24 at 12:35 PM, an interview with CNA #1, she confirmed the staff did not offer to assist residents with hand hygiene in Dining Room C prior to serving lunch. On 05/20/24 at 12:40 PM, during an interview with the Physical Therapy Assistant (PTA), she reported the (3) residents that came into the dining room had just ended therapy prior to lunch. She confirmed the therapy staff do not assist residents in washing their hands before going to the dining room. She stated, "Residents like to stay in the therapy room as long as they can before going to lunch."	M1570		