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
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 an annual recertification survey at the facility from 05/28/2024 through 05/30/2024. 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 requirements and cited M500 and M715.	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 treatment, to not be limited in his/her choice of a	M 500		7/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 500	Continued From page 1 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 in conformance with State law;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 500	Continued From page 2 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 practitioner/physician assistant in his medical	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 500	Continued From page 3 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, interviews, record review, and facility policy review, the facility failed to ensure a resident was free from the use of physical restraints, as evidenced by an observation of a resident wearing a seat belt with no facility documentation of risk and benefits, physician order, consent, monitoring,	M 500	* An order, medical symptom for use or monitoring for the seatbelt and consent was obtained by the Minimum Data Set (MDS) Nurse on 05/31/2024 for the use of the seat belt as a restraint on Resident #17. A restraint assessment was done by the Registered Nurse Supervisor on 05/31/2024 and Risk and benefits were explained to the resident representative by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 500	Continued From page 4 assessments or medical symptoms for restraint use for one (1) of 15 sampled residents. (Resident #17) Findings include: Review of the facility's policy, "Physical Restraint Application", revised 8/2/22, revealed, "The purpose of this procedure is to provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints ...Physical restraints are defined ...as any manual method or physical or mechanical devise, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement ...The resident must be physically and cognitively able to self-release devices such as ...seat belts ...If a resident cannot mentally and physically self-release, then the device is considered a restraint ..." On 05/28/24 at 11:40 AM, during an observation, Resident #17 was sitting in a wheelchair and had a seat belt that was attached to the chair and buckled in the front. His hands were contracted. He kept his hands positioned around his abdominal area. On 05/29/24 at 2:26 PM, in an observation an interview with Certified Nursing Assistant (CNA) #1, she stated Resident #17 was unable to use his hands and could not release the seat belt buckle without assistance. Resident #17 was sitting in his wheelchair with the seat belt device in place. CNA #1 asked Resident #17 to unbuckle his seat belt, but he said that he could not unbuckle it and asked the CNA to do it.	M 500	the Registered Nurse Supervisor on 05/31/2024. * All residents requiring a restraint have potential to be affected by this deficient practice. * An inservice will be conducted by the Staff Development Nurse beginning on 06/13/24 for all Nurses and Certified Nursing Assistants. The inservice will cover the definition of a restraint and the facility's process for restraint assessment and use. *The Resident Care Coordinator will audit and observe for restraint assessment and use, twenty percent of residents once a week X 12 weeks beginning on 06/13/24. The results of these audits will be brought to the monthly Quality Assurance Committee meeting beginning 07/05/24 X 3 months and changes will be made as deemed necessary by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 500	Continued From page 5 A record review of the "Admission Record" revealed the facility admitted Resident #17 on 6/18/2022 and he had current diagnoses including Acquired Absence of Right Leg and Left Leg, Above the Knee. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/4/24 revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Review of the medical record revealed there was no documentation Resident #17 had a wheelchair seat belt restraint, consent, risk and benefits of restraint use, restraint assessment, physician order, medical symptom for use or monitoring for the seat belt. On 05/30/24 at 11:06 AM, in an interview with the Director of Nursing (DON) she stated the facility did not consider the lap belt for Resident #17 as a restraint because they viewed it as a support device for the resident. She confirmed that by definition, it should have been considered a restraint and the facility should have obtained a physician's order for the device.	M 500		
M 715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This Statute is not met as evidenced by: Level II	M 715	* The identified medications were discarded properly on 05/28/2024 and	7/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 715	Continued From page 6 Based on observation, staff interview, and facility policy review, the facility failed to discard expired medications from one (1) of three (3) medication storage rooms observed. (Central Station) Findings include: Record Review of the facility's "Medication Storage", revised 07/17/23, revealed, "Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the ...medication rooms according to the manufacturer's recommendations ...Policy Explanation and Compliance Guidelines ...8. Unused Medications: The ...medication rooms are routinely inspected by the consultant pharmacist for discontinued ...medication with worn." In an observation and interview with Registered Nurse (RN) #2, on 5/28/24 at 11:33 AM, on central station there were expired medications in a cubicle in the medication room stored in blister packs (dose packaging for pharmaceutical tablets or capsules) for Resident #36. The medications included Furosemide 40 milligrams (mg) that expired on 1/2/24, Vistaril 25 mg expired on 1/2/24, Aricept 20 mg expired on 10/28/23, and Zoloft 25 mg expired on 2/27/24. RN #2 explained that all nurses should check the medication rooms and medication carts to ensure there were no expired medications. During an interview with the Director of Nursing (DON) on 05/30/24 at 11:39 AM, she stated it was her expectation that the nurses check medications for expiration dates before administering them and to remove expired medications from the medication carts and medication rooms.	M 715	reordered as needed. * All residents have potential to be affected by this deficient practice. * A 100% audit medication rooms and medication carts was conducted by the Director of Nursing and Resident Care Coordinator on 05/30/2024 and medications were discarded as needed. The Staff Development Nurse will inservice all nurses on identifying expiration dates and proper destruction of expired medications beginning 06/13/24. * The Resident Care Coordinator and/or Director of Nursing will audit medication rooms and carts beginning 06/13/24 for expired medications monthly X 4 months The results of these audits will be brought to the monthly Quality Assurance Committee meeting beginning 07/05/24 and changes will be made as deemed necessary by the Quality Assurance Committee.	

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
	51CR	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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