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
	18BC	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #26878, at the facility from 10/28/24 through 10/29/24. The complaint was investigated related to resident safety and neglect. 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.	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		11/19/24

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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	M 500		

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

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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 interview, record review, and facility policy review, the facility failed to ensure a resident was free from neglect, as evidenced by, on 10/21/24, at approximately 2:45 PM, after returning to an outing at a local fair, a resident	M 500	Resident #1 was located and removed from the facility van, the van was cleared with no other residents present, Resident #1 was assessed by nursing staff on 10/21/2024 and Resident #1 was assessed by the Nurse Practitioner on 10/21/2024. There were no injuries,	

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M 500	Continued From page 4 was left in the facility's transportation van until approximately 5:00 PM, for one (1) of three (3) sampled residents. Resident #1 Findings include: A review of the facility's policy, "Abuse Prevention Program," modified 8/2/22, revealed " ...Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation ..." On 10/28/24 at 11:20 AM, during an interview with the Administrator, he stated that on 10/21/24, following a trip to a local fair, five (5) residents were in the facility's transportation van. At approximately 2:45 PM the van returned to the facility and all the residents were unloaded except Resident #1. The van driver, who is also responsible for central supply, was requested to retrieve supplies for another resident. The front desk staff reported she always had eyes on the resident, while the resident was in the van alone, which was approximately 20 minutes. The Administrator confirmed that the Director of Nursing (DON) called him on 10/21/24 and advised him that Resident #1 was found inside the facility van at approximately 5:00 PM. The Administrator also stated that although the facility had video surveillance, the surveillance system was not operational on 10/21/24. During an interview on 10/28/25 at 12:45 PM, the van driver stated that on 10/21/24 at approximately 2:45 PM, he arrived at the facility with five (5) residents. Resident #1 was the only resident who was in a wheelchair. During their return to the facility as the residents were exiting, the van driver was called to get supplies for another resident, leaving Resident #1 in the van.	M 500	illnesses, or complaints identified or voiced by the staff, provider, or Resident #1 on 10/21/2024. All residents who are transported via the facility van have the potential to be affected by the deficient practice. The Quality Assurance Committee (QAC) met on the morning of 10/22/2024 to discuss the events of 10/21/2024. It was the recommendation of the QAC to put into place a Final Transportation Vehicle Inspection and Log. This inspection is completed by the vehicle Driver and another Front Office Staff Member prior to the vehicle being parked and left unattended at the end of the transport. This Inspection includes but is not limited to inspection of the interior of the van to ensure no residents remain in the vehicle prior to the vehicle being parked and left unattended. The QAC also approved a Transportation Vehicle Inspection Log which is kept at the front desk and is to be completed once the inspection is completed and all transported residents are safely inside the facility. All transportation vehicle drivers and front office staff were in-serviced on the Transportation Vehicle Inspection and Log on 10/22/2024. The Transportation Vehicle Inspection and Log process was put into effect on 10/22/2024. The Administrator will audit the Transportation Vehicle Inspection Log 5 times weekly x 2 weeks, then once weekly x 3 months beginning 10/22/2024 to ensure all inspections are being	

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M 500	Continued From page 5 He stated he was only gone for five (5) to six (6) minutes. Front Desk #1 informed him that she would watch Resident #1 while he went for supplies. Upon returning to the van, he assisted Resident #1 off the van and brought him to the front lobby. On 10/28/24 at 12:55 PM, during an interview with Front Desk #1, she stated that while the van driver was getting supplies for another resident, she walked outside, then back inside, and kept eyes on Resident #1 the entire time he was in the van. Approximately 10 minutes later, the van driver returned and assisted the resident off the van. On 10/28/24 at 1:32 PM, during a phone interview with Registered Nurse (RN) #1/Supervisor, she stated that on 10/21/24 at approximately 5:00 PM during the evening meal, she was informed the facility staff could not locate Resident #1. RN #1 explained that all staff began to search for Resident #1, both inside and outside of the facility. Certified Nurse Assistant (CNA) #1 stated that Resident #1 went to the fair earlier and went to the front of the facility and found Resident #1 in the locked van. She further explained that Licensed Practical Nurse (LPN) #1 retrieved the facility van keys from Front Desk #1 and opened the van. The van driver had returned to the facility and assisted with removing Resident #1 from the van. RN #1 stated the incident was reported to the Director of Nurses (DON), and the Nurse practitioner (NP) was notified. During an interview on 10/28/24 at 2:01 PM with LPN #2, she confirmed that on 10/21/24 during dinner time at the facility, Resident #1 was not present in the dining room, the staff went to search for him and found him in the facility van.	M 500	performed daily. Audits will be reviewed by the QAC monthly x 3 months beginning 11/18/2024 to ensure sustained compliance.	

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M 500	Continued From page 6 The van was locked, and LPN #1 received the keys from the front desk staff and opened the van. Someone had called the van driver back to the facility and he came and assisted in getting Resident #1 out of the van, which was at approximately 5:00 PM. On 10/28/24 at 2:10 PM, during a phone interview with CNA #1, she revealed that when she realized Resident #1 was not in the dining room during the evening meal, she remembered he had gone with the other residents to the local fair. She immediately went to the van, which was in the handicapped parking spot, and saw him inside the van. CNA #1 recalled that a nurse got the keys from the front desk staff and the van driver assisted with getting the resident off the van and into the facility. On 10/28/24 at 3:15 PM, during an interview with CNA #2, she stated that on 10/21/24 at approximately, 4:00 PM, she observed Resident #1 in the front lobby playing basketball. On 10/28/24 at 3:24 PM, during a phone interview with LPN #1, she stated that on 10/21/24, when the facility staff discovered that Resident #1 was missing, she searched his room and bathroom. When he was found to be locked in the facility van, she got the keys from the front office to get him out of the van. She said the van was parked in its designated parking spot. She explained that someone had called the van driver to assist with getting the resident out. LPN #1 further explained that when the residents returned from the fair, she had documented that Resident #1 had returned in the computer system but admitted that she had not actually observed him in the facility.	M 500		

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M 500	Continued From page 7 On 10/28/24 at 3:40 PM, in a follow up interview with Front Office #1, she recalled giving a nurse the van key on 10/21/24 sometime before she got off work at 6:00 PM but was unable to recall why the key was needed, the exact she gave the key out, and the name of the nurse she gave the key to because there was a lot of activity in the lobby. On 10/28/24 at 4:15 PM, during a follow up interview with the Administrator, he reiterated that following the outing to the fair, the residents returned to the facility on 10/21/24 between 2:15 to 2:30 PM. Later that day, after leaving the facility for the day, he received a phone call from the DON, informing him that she received a phone call at or around 6:00 PM stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner to assess the resident. The next day, he received statements from the van driver and Front Office #1. The Administrator stated that he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for 19 years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM. He was also unaware that Front Office #1 had given the van key to a nurse around that same time. The Administrator was unable to explain the discrepancies in the statements made by the facility staff and the timeline of the event. The Administrator explained the facility held an emergency Quality Assurance (QA) meeting on 10/22/24 because a resident being left on the van for any amount of time could be an issue.	M 500		

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M 500	Continued From page 8 On 10/29/24 at 9:27 AM, an interview with the Nurse Practitioner (NP) revealed on 10/21/24 at approximately 6:00 PM, he received a phone call from RN #1, stating that Resident #1 was left in the facility van for an undetermined amount of time. The NP explained that he did not witness Resident #1 being left in the facility's van. His note on 10/21/24 reflected to the best of his knowledge at the time of the incident what had been reported by the nursing staff. The NP stated he had provided an addendum to his note to clarify that he had no knowledge of how long the resident was left on the van. Following the incident as it was reported to him, he ordered basic blood work as the concern was that the resident had been left on the van for an undetermined amount of time. On 10/29/24 at 9:57 AM, an interview with the DON confirmed on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but that he had been found in the facility van. The NP was notified, and she had called the Administrator to let him know what the RN Supervisor had reported. She stated the facility completed in-services regarding completing documentation correctly since LPN #1 admitted that she had documented Resident #1 as being in the facility on 10/21/24 without seeing him. The facility also completed in-services on Abuse and Neglect. On 10/29/24 at 10:03 AM, in a follow up interview with RN #1, she stated that when it was reported to her that Resident #1 was missing, all staff started searching resident rooms, the shower room, and the outside courtyard. She did not issue a missing resident alert because he was found in the facility van. She confirmed that she went outside to the van and both the back and	M 500		

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front door was open. She confirmed she observed the van driver return to the facility in his truck, and he was wearing a white t-shirt and shorts.

In a follow up interview with LPN #1 on 10/29/24 at 5:15 PM, she stated she found Resident #1 in the facility van, secured in a seatbelt, and the van door was locked. She explained she went and got the keys from Front Office #1, and another staff member called the van driver, who quickly arrived back to the facility.

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/24/23 with diagnosis including Unspecified Intellectual Disabilities and Dementia.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.

A record review of the "Quality Assessment and Assurance Committee Minutes October 22, 2024" revealed, " ...Emergency QA meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour ..."

Record review of the "Progress Note" from the NP, dated 10/21/24, revealed, " ...Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by

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M 500	Continued From page 10 facility nursing staff regarding the patient spending several hours in the van after going to the fair ...At approximately 19:30 (7:30 PM) I came and evaluated the patient ...Document e-signed ...on Oct 22 2024 ..." Record review of the "Addendum" from the NP Progress Note revealed, "Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several hours ...Document e-signed on Oct 29 2024 ..."	M 500		