STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255149	A. BUILDING _____ B. WING _____	02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PETAL	908 S GEORGE STREET PETAL, MS 39465

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 2/1/21 to 2/4/21. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiency F880 at an "E" level. The facility census on the day of entrance was 55 and the facility had a license for 60 beds.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		3/1/21

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

Electronically Signed | 02/22/2021

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F 880	Continued From page 1 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 2 Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection related to cross contamination during wound cleansing, failure to remove soiled gloves and perform hand hygiene prior to starting wound care for Resident #7, and applying ointments directly to open wounds with a gloved hand for Resident #7 and Resident #9 for two (2) of three (3) pressure wound care observations Resident #7 and Resident #9. Findings Include: The facility's, "Wound Care" procedure, dated February 2016, revealed staff should put on exam gloves, loosen the tape, remove the old dressing, pull the gloves over dressing and discard into appropriate receptacle. This policy noted staff should then wash and dry hands thoroughly. The facility's, "Standard Precautions" policy, revised October 2018, revealed the staff should conduct hand hygiene after contact with items in the resident's room. This policy noted gloves are changed as necessary during the care of a resident to prevent cross-contamination from one body site to another. Gloves should be changed as necessary during the care of a resident. Resident #7 An observation on 02/01/21, at 12:10PM, revealed Resident #7 sitting in a wheelchair. Resident #7 stated she has a wound on her buttocks, but the wound is healing. On 2/3/2021 at 11:10 AM, observed Registered Nurse (RN) #2 perform wound care to a Stage 2 Pressure Ulcer on Resident #7's sacrum. RN #2	F 880	On February 4, 2021, Registered Nurse (RN) #2 was immediately provided training by RN #1,the Director of Nursing, on proper wound care procedures to prevent the spread of infection. Resident #7 and Resident #9 were provided proper wound care treatment by the RN Supervisor to prevent the spread of infection on February 5, 2021 as observed by RN #1, the Director of Nursing. All residents who require wound care treatment have the potential to be affected by the alleged deficient practice. RN #2 was sent for training by a Certified Wound Care Nurse at a local sister facility on February 10, 2021. The training included proper wound care procedures to prevent the spread of infection through wound cleansing, changing of gloves, hand hygiene, and proper methods to apply ointments to a wound. All RN and Licensed Practical Nurse (LPN) staff will receive training by the Infection Preventionist RN and Wound Care RN from a sister facility related to general infection prevention practices and infection prevention practices specific to the spread of infection during wound care treatment on 2/23/21 and 2/24/21. All RN and LPN staff will successfully returned demonstrated infection prevention practices related to wound care treatment procedures on 2/24/21 as observed by the Certified Wound Care Nurse. Beginning 2/24/21, the Resident Care Coordinator (RCC) RN will observe RN and LPN staff perform resident wound care treatments daily times two weeks, then twice weekly times four weeks, and then monthly times	

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F 880	Continued From page 3 used a clean right gloved hand to pull the curtain for privacy, then used the same gloved hand to remove the soiled dressing. RN #2 then used the same right gloved hand to touch Resident #7's sacral wound during an assessment of the wound. RN #2 changed gloves and conducted proper hand hygiene then cleaned the wound with a back and forward motion, with the gauze soaked with wound cleanser, across the wound eight (8) times. RN #2 applied zinc cream to her gloved index finger and applied it to the wound area directly with her gloved hand. RN #2 then picked up the new border dressing with the same soiled gloved hand and applied it directly to the wound. On 2/4/20, at 10:51 AM, in an interview with RN #2/Staff Development/Infection Control Nurse, she stated she should have changed her gloves when she used her right gloved hand to close the privacy curtain. RN #2 stated she should have washed her hands and changed her gloves after cleaning the wound because it can cause contamination of the wound. RN #2 stated she should clean the wound in one direction and not in a back and forth motion. RN #2 stated cleaning the wound back and forward can cause cross contamination and skin damage. She stated she should have used an applicator to apply zinc to wound and confirmed it was the facility's policy to use an applicator. RN #2 stated the most harmful thing she did when providing wound care to Resident #7, was cleaning the wound back and forth and applying the zinc with a gloved finger. On 2/4/21 at 11:14 AM in an interview with RN #1 Director of Nursing (DON) , she stated the facility's policy is to clean a wound by wiping in one direction and dispose of the 4x4 and then	F 880	three months. During these observations, any breech in infection control practices while performing wound care treatment will result in immediate correction of the deficient practice through education with the staff member who performed the deficient practice, and return demonstration of proper infection control practices related to wound care treatment. Initial wound care treatment observations will be submitted on 2/26/21 to the Quality Assurance Committee for review. Wound care observations made by the RCC RN will continue to be submitted to the Quality Assurance Committee on a monthly basis to monitor for the effectiveness of this plan of correction.	

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F 880	Continued From page 4	F 880		

use another 4 x4 to repeat the process. The DON stated when RN #2 did not follow the facility's policy for wound care, it could cause infection to the resident's wound. The DON stated RN #2 should have applied the zinc ointment directly on the gauze and should have not used her finger to apply the zinc ointment to the wound area. The DON stated the most serious thing that RN #2 did when cleaning the wound for Resident #7 was to improperly clean the wound.

Record review of Resident #7's Face Sheet revealed the resident was admitted to the facility on 2/8/19, with diagnoses of Major Depressive Disorder and Paraplegia.

A record review of the Physician Orders for Resident #7, dated 1/15/21, revealed an order to cleanse the sacral ulcer with cleanser, pat dry, apply zinc cream to site and cover with border dressing every day shift and as needed.

A record review of the Comprehensive Minimum Data Set (MDS) for Resident #7, with an Assessment Reference Date (ARD) of 11/2/20, revealed the MDS was coded for pressure ulcer.

Resident #9
On 02/01/21, 11:35 AM, an observation revealed Resident #9 lying in bed, with a boot on the right foot.

On 2/3/2021, at 11:25 AM, observed RN #2/ Infection Control Nurse perform wound care on Resident #9's right lateral ankle Stage 2 Pressure Ulcer. RN #2 used hand sanitizer and applied gloves prior to removing Resident #9's protective boot and sock. RN #2 then used the same gloved hands and removed Resident #9's soiled wound

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F 880	Continued From page 5	F 880		

dressing and examined the wound without changing gloves. She then changed the soiled gloves and used hand sanitizer and applied clean gloves. RN #2 then picked up the saturated gauze, that had been saturated with wound cleaner, and used a back and forth motion ten (10) times to clean the wound and then used her index gloved finger to apply the Santyl ointment. RN #2 then applied the dressing to the wound without sanitizing her hands and changing her gloves.

On 2/4/21, at 11:02 AM, in an interview with RN #2/Staff Development Nurse/Infection Control Nurse, stated that by cleaning the wound in a back and forward motion it can cause cross contamination of the wound. RN #2 stated she should have not applied the Santyl to the wound with her finger and should have used an applicator. RN #2 stated by using her finger, it can get on other skin that surrounds the wound and can cause skin problem.

On 2/4/21, at 11:19 AM, in an interview with DON, she stated that RN #2 should never have clean wound in a back and forward motion and stated that it can cause cross contamination of the wound. The DON stated RN #2 should have used an applicator instead of using a finger. The DON stated the Santyl could get on more than wound area. The DON stated that Santyl is a debridement agent and can eat your healthy tissue causing damage.

A record review of Residents #9's Physician Order, dated 1/20/21, revealed an order for wound care to the Stage II area on the right lateral ankle. The Physician's order noted to cleanse the wound with wound cleaner, pat dry,

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F 880	Continued From page 6	F 880		

apply Santyl ointment to the site and cover with a foam border dressing every day shift.

A record review of the Comprehensive MDS with the ARD date of 11/6/20, revealed in Section M, Resident #9 was coded for pressure wounds.

Record review of Resident #9's Face Sheet revealed the resident was admitted to the facility on 9/28/19 with a diagnosis of Chronic Diastolic (Congestive) Heart Failure.

A record review of RN #2's "Treatment/Skin Care Skills Checklist", dated 06/24/2020 and 12/3/2020, revealed she passed both the skill tests that included care of the Pressure Ulcer.

A record review of an in-service on Infection Control, dated 11/23/20 revealed RN #2's signature on the sign in sheet.