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 _____	08/10/2019

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 **Amended state 2567: Corrected census and licensed bed data; numbers were reversed.** The State Agency (SA) conducted an annual recertification survey and a partial extended survey for Complaint Investigation (CI) MS #16048, from 8/5/19 to 8/10/19. The SA substantiated the complaint for Resident #2, a cognitively impaired resident, with no history of sexually transmitted disease (STD), tested positive for Trichomonas, a STD. The facility was found not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA identified an Immediate Jeopardy (IJ) that began on 7/9/19, when the facility failed to protect a confused, demented resident from possible sexual abuse, failed to fully investigate how Resident #2 tested positive for Trichomonas, a sexually transmitted disease, and failed to report to the local law enforcement regarding a possible crime being committed for sexual abuse. Resident #2 was seen at the hospital Emergency Room (ER) for shortness of breath on 7/9/19, and a urine sample tested positive for Trichomonas for Resident #2. Resident #2 had three (3) prior urinalysis results that were negative for Trichomonas, as recent as 6/20/19. The failure to fully investigate the cause for Resident #2's positive Trichomonas test, which indicated a sexually transmitted disease, failure to protect the resident from possible further sexual abuse, placed this resident and other confused, demented residents in a situation that was likely to cause serious injury, harm, impairment, or death.	M 000		

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 _____	08/10/2019

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	Continued From page 1 On 8/7/19 at 10:25 AM, the SA notified the facility's Administrator of the IJ. The IJ existed at: M500-Resident Rights The facility submitted a Credible Removal Plan on 8/9/19, in which the facility alleged all corrective actions to remove the IJ were completed on 8/9/19, and the IJ removed on 8/10/19. The SA validated the Action Plan on 8/10/19, and determined the IJ was removed, prior to exit. Therefore the scope and severity for M500 was lowered from a "Level IV" to a "Level II", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 120 beds, with a census of 109.	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;	M 500		8/28/19

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 _____	08/10/2019

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 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 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	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 _____	08/10/2019

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 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; 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;	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 _____	08/10/2019

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 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 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	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 _____	08/10/2019

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 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: Based on resident interview, staff interview, record review, hospital record review, hospital staff interview, facility investigation review, and facility policy review, the facility failed to investigate and put measures in place to protect residents from possible sexual abuse, when the facility was notified that Resident #2, a cognitively impaired resident, tested positive for Trichomonas, a sexually transmitted disease for one (1) of 22 residents reviewed for abuse, Resident #2. The facility's failure to protect Resident #2, and all other cognitively impaired residents, from possible sexual abuse, placed Resident #2 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ), which began on 7/9/19, when the hospital notified the facility that Resident #2 tested positive for Trichomonas, a sexually transmitted disease, and Resident #2 returned to the facility without thorough investigation or protective measures put in place. The facility's Administrator was notified of the IJ on 8/7/19, at 10:25 AM, and provided with the IJ template. An acceptable credible Removal Plan was provided by the facility on 8/9/19, in which	M 500	1. The State Agency and Attorney General Office was notified of the positive Trichomonas results on 07/09/19 by the Administrator and Director of Nursing. An interview was done with Resident #2's room mate, Resident # 74, on 07/10/19 by the Director of Nursing with no unwanted visitors no bothersome behavior or mistreatment toward them by visitors, residents or staff. An interview with Residents # 2 was done on 07/11/19 by the Director of Nursing and Administrator with negative responses in the areas of inappropriate behavior towards her from others, being afraid and any unwelcome visitors. The local Police Department was nofified on 08/07/19 by the Administrator and arrived at the facility at approximately 11:05 am with no further action recommended at this time. On 08/09/19, a repeat urinalysis was done on Resident #2 the Licensed Practical Nurse and the results were negative. 2. A 100% chart audit was conducted by the Director of Nursing and Resident Care Coordinators 08/09/19 focusing on the most recent urinalysis for Trichomonas. The results of this chart audit revealed all recent urinalysis results were negative for Trichomonas. A urinalysis was done on	

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 _____	08/10/2019

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 6 the facility alleged all corrective actions were completed as of 8/9/19, and the IJ was removed on 8/10/19. The State Agency (SA) validated the Removal Plan and determined that the IJ was removed on 8/10/19, prior to exit. Therefore, the scope and severity for the IJ at M500-Resident Rights, was lowered from a scope and severity of "Level IV" to a scope and severity of "Level II", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's "Resident Rights" policy, undated, noted the resident has the right to be free from mental and physical abuse. The facility's policy, "Abuse Prevention, Investigation and Reporting", dated 2/15/10, revealed the facility shall comply with all Regulations, Laws, Policies, Procedures and guidelines for prevention, investigation and reporting suspected Abuse. All employees shall report any suspected or alleged Resident mistreatment, suspicious bruising, neglect, mental or physical abuse, or injuries of unknown origin to the Nurse Supervisor or Department Head ....Appropriate action will be taken based on results of the investigation. All incidents of possible abuse will be initially investigated by the Administrator and/or designated facility staff. Review of a written complaint, reported by an outside source, on 7/10/19, revealed Resident #2 tested positive for Trichomonas on 7/9/19, and had previously tested negative for Trichomonas	M 500	08/09/19 on female residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or below by nursing staff and all results were negative for Trichomonas. An interview was done on 08/09/19 by Resident Care Coordinators, Licensed Practical Nurse and Social Services on residents that have a BIMS score greater than seven (7)these interviews revealed thirty (30) out of thirty (30) residents expressed no concerns related to potential sexual abuse. All residents have potential to be affected. 3. Nurses, Certified Nurses Assistants, Housekeeping staff, Laundry staff, Dietary staff, Business Office staff, Social Service staff, Activity staff, Central Supply, Medical Records and Maintenance staff were inserviced on Abuse, Neglect and Exploitation to include reporting of reasonable suspicion of a crime, by the Staff Development Nurse beginning on 08/07/19. Employees were not allowed to work until they had been inserviced. The inservice is also given to new employees during orientation. Hourly Safety rounds that focus on New episodes of: being withdrawn, yelling, screaming, crying, fighting, expressions of fear of others, threats of suicide or self harm, problems with walking or sitting, were initiated on 08/09/19 to be done daily times one (1) months. These rounds are to be done by Nurses and Certified Nursing Assistants and any problems or concerns with these rounds are to be reported to the Nurse Supervisor immediately.	

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 _____	08/10/2019

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 7 on 6/20/19. Record review revealed Resident #2 was transferred to the hospital on 7/9/19, for respiratory issues; and returned to the facility on 7/10/19. The Discharge Summary revealed a Diagnosis of Trichomonas Infection. The History and Hospital Course documented: "Of note, patient's UA showed evidence of Trichomonas infection. I discussed with the ID specialist, she recommended treatment and reporting the case {to} the social services for further evaluation. Patient denies sexual contact or sexual abuse of any kind..." Review of a urinalysis, for Resident #2, with a documented collection time of 7/9/19 at 04:55, revealed Rare A Trichomonas was present in the urine, with a normal reference range of "none seen". The medical record revealed this was a catheterized specimen. A urinalysis, dated 6/20/19, revealed no Trichomonas was seen. Review of the local hospital record revealed Resident #2 received Metronidazole (Flagyl) 2000 milligrams by mouth (po) at 1:20 PM on 7/9/19, which is a treatment for Trichomonas. Record review revealed urinalysis results for Resident #2 on 6/20/19, 9/2/18, and 7/6/18, were all negative for Trichomonas. The Urinalysis result on 7/9/19, for Resident #2, tested positive for Trichomonas. In an interview on 8/5/19 at 3:32 PM, the State Epidemiologist stated that the only way to contact Trichomonas is through sexual contact. He stated based on the positive Trichomonas result for Resident #2 on 7/9/19, with a previous negative result, you had to treat the resident for	M 500	4. Documentation of these Hourly Safety Rounds are given to the Director of Nursing daily Monday through Friday to monitor for any problems or concerns noted. The results of these rounds will be brought to the Quarterly Quality Assurance Committee meeting by the Director of Nursing to evaluate the effectiveness 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 _____	08/10/2019

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 8 Trichomonas. Interview with the Director of Nursing (DON) on 8/5/19 at 4:00 PM, revealed Resident #2 went to the hospital on 7/9/19, for respiratory issues and they diagnosed and treated her for Trichomonas. The DON confirmed the Urinalysis results from the admitting hospital on 7/9/19, showed Resident #2 tested positive for Trichomonas, and her previous urinalysis results were negative for Trichomonas, prior to 7/9/19. The DON stated she talked to Resident #2's Primary Care Physician (PCP), who is also the Medical Director, who stated Resident #2 could have had Trichomonas a long time. The DON stated she talked to Resident #2, who denied having sex with anyone, but stated Resident #2 is confused. The DON stated she talked with Resident #2's brother, the resident's Responsible Party (RP), who reported he had not been aware of Resident #2 ever having a sexually transmitted disease. The DON stated she reviewed past video footage at Resident #2's door/hallway, and there was no unusual activity noted regarding other residents visiting, and only the brother visited the resident. The DON stated there was only one (1) male nurse who worked the 11:00 PM-7:00 AM shift and one (1) male Certified Nursing Assistant (CNA) who worked the 3:00 PM-11:00 PM shift. There had been no testing of either staff member for Trichomonas. The DON stated the facility looked at abuse, because that is what you think of (with a positive Trichomonas test). The DON stated, "I don't think she was abused, but we looked at it as best we could". The DON stated if someone is positive for Trichomonas, then you look for sexual assault when the resident can't give permission. The DON stated it is against a resident's rights if they have been abused. The DON stated no other residents had tested	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 _____	08/10/2019

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 9 positive for Trichomonas. She also stated there was nothing out of the ordinary when viewing the video and interactions with other residents and no male residents were paying particular attention to Resident #2. The DON stated she was not sure if there had been any abuse training after this event. Further interview with the DON on 8/6/19 at 9:37 AM, confirmed Resident #2 had not been out on pass at any time during 2019, and as far as she could tell, had not been out in 2018. Facility letter-head documents, dated 8/6/19, and signed by the DON, reflected this data. Interview with the Administrator on 8/6/19 at 9:42 AM, revealed the facility had not tested male staff for Trichomonas since Resident #2 tested positive. Interview with the DON on 8/6/19 at 10:54 AM, revealed she had initially asked the hospital to repeat a UA after the first showed Trichomonas, but the hospital did not repeat the UA. The DON stated during the investigation, some of the nurses stated Resident #2 had a foul vaginal odor, but not sure for how long. The DON stated all findings were discussed during the Quality Assurance (QA) meeting. The DON stated she requested from Resident #2's PCP to repeat the UA here at the facility, but he stated not to repeat it since Resident #2 had already been treated. A message was left on 08/06/19 at 11:46 AM, for the Hospital Laboratory (Lab) Director to return a call to the surveyor at the facility. On 08/06/19 at 11:52 AM, a call was placed to the Hospital Emergency Room (ER) to speak with the ER Nurse Manager, and no one answered the page.	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 _____	08/10/2019

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 10 On 08/06/19 at 1:26 PM, interview with Registered Nurse (RN) #6, revealed she did remember Resident #2 having a foul vaginal odor at one time, and stated a UA was sent for testing. Interview with RN #1, on 08/06/19 at 1:30 PM, revealed there was only one (1) resident on the unit that was being monitored for sexual behavior, Resident #11. RN #1 stated Resident #11 would touch others and touch employees. Review of Resident #11's medical record revealed the last UA was 8/23/17, which was negative for Trichomonas. During a phone interview, on 08/06/19 at 1:51 PM, Certified Nursing Assistant (CNA) #2 confirmed writing a statement on 7/9/19 at 5:30 PM, regarding Resident #2 and the foul/strong vaginal odor prior to her going to the hospital in July 2019. CNA #2 stated she was not aware of any male residents paying attention to Resident #2 or being in her room. On 08/06/19 at 02:10 PM, an attempt was made to interview the Nurse Manager for the hospital ER and the ER Nurse that collected the sample of urine from Resident #2. The Nurse Manager stated that the nurse who provided care to Resident #2 was on vacation and would not be back for a couple of weeks. The Nurse Manager referred questions to the hospital Risk Management Department. Per the Risk Manager, no further interview would be allowed per advice of their legal counsel. On 08/06/19 at 2:44 PM, a phone interview with Resident #2's PCP, revealed he had been the resident's doctor for years, not just in the nursing home, and would pull her chart and return the	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 _____	08/10/2019

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 11 call. In a further interview on 08/06/19 at 3:09 PM, Resident #2's PCP stated he has treated Resident #2 since 1990, and Resident #2 had never had a positive UA for Trichomonas, and had not been treated for any other Sexually Transmitted Disease (STD). He also stated there was no indication of sexual trauma when he examined her. In an interview on 08/06/19 at 3:06 PM, CNA #4 confirmed a written statement on 7/9/19, that Resident #2 previous had a strong foul odor to her vaginal area that she had not noticed before. On 08/06/19 at 04:21 PM, in an interview with the DON, she stated law enforcement was not called regarding Resident #2, because they felt like there was nothing to report (no crime) after the investigation. In an interview, on 08/07/19 at 9:40 AM, the DON stated the ER Nurse had told her there was no visible signs of vaginal trauma on exam at the hospital, but no documentation was found for support. During an interview, on 08/07/19 at 10:10 AM, the Facility Administrator stated she first became aware that Resident #2 was positive for Trichomonas when the Hospital called on 7/9/19, from their Social Service Department, and notified the DON. The Administrator stated she and the DON were both responsible for conducting investigations. The Administrator stated they talked to the staff, viewed the video, talked to the Medical Director/Resident #2's PCP, and called the nurse on the floor at the hospital. The Administrator stated they talked to the ER Nurse that collected the sample of urine in the ER, and the ER nurse denied having seen any	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 _____	08/10/2019

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 12 signs of bruising or trauma to Resident #2. The Administrator stated the facility requested that the hospital repeat the test, but had been told they couldn't, because the antibiotic had been started. The Administrator confirmed the AG's Office, the State Agency (SA), the Medical Director/Resident #2's PCP, and Resident #2's Responsible Party (RP) were notified, but the local law enforcement was not notified. The Administrator stated Resident #2's brother/RP denied having knowledge of Resident #2 ever being sexually abused or being positive for a sexually transmitted disease. The Administrator stated that Resident #2's PCP had said that Trichomonas could have been dormant, then all of the sudden flair up. The Administrator stated she did not call the local health department for guidance. The Administrator stated that no employees were tested at that time and no other residents were tested for Trichomonas. The Administrator stated, "We felt like it didn't happen" (no sexual assault), "so we didn't do anything else". The facility did not put any monitors in place, nor further investigate to determine the possible source of the Trichomonas for Resident #2. In an interview, on 08/07/19 at 10:40 AM, the hospital Social Worker (SW) confirmed Resident #2 had a negative urine at the nursing home on 6/20/19, and on 7/9/19 at the hospital ER, Resident #2 tested positive for Trichomonas. The SW stated when she interviewed Resident #2, she was told by Resident #2 that she lived at home with her mother. The SW stated the resident was unable answer questions regarding any sexual activity, was confused and disoriented, and was not a reliable historian. During a phone interview, on 08/07/19 at 02:00 PM, the Criminal Investigator for the AG's Office	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 _____	08/10/2019

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 13 stated that the facility informed him that Resident #2's PCP had told them that Trichomonas can be dormant and not active and undetectable, then flair up. He also stated the facility had informed him there was no evidence of forceful sex seen for Resident #2. Record review revealed a repeat Urinalysis for Resident #2, after antibiotic treatment, that was collected on 8/6/19 at 6:19 PM, with no Trichomonas seen. On 08/08/19 at 10:34 AM, interview with the District Ombudsman revealed that she nor the local Ombudsman was aware of the incident involving Resident #2 being positive for a STD. She stated that she had not had any other complaints from other residents regarding sexual abuse. In a phone interview on 08/08/19 at 02:42 PM, the Lab Director at the Hospital reported that as advised per Risk Management, that they would be allowed to talk with the surveyor later, but "not this week", after an interview was attempted. In a post exit interview on 8/13/19 at 12:24 PM, the hospital Lab Director and Risk Manager revealed the lab reports to the doctor any unusual findings. The Lab Director confirmed a Urinalysis for Resident #2 was not repeated after the finding of Trichomonas being present on 7/9/19. The Lab Director also stated a test is either Positive or Negative, if Trichomonas was seen, then it is Positive. The Risk Manager stated as far as the hospital could tell, proper collection/labeling of the urine sample was done and the Emergency Room Nurse that collected the sample is on vacation and unavailable for interview at this time. The Risk Manager stated the Emergency Room	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 _____	08/10/2019

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 14 Physician is also unavailable at this time for an interview. The facility admitted Resident #2 on 9/26/16, with the diagnoses which included, High Blood Pressure, Non-Alzheimer's Dementia, Seizure Disorder, Osteoarthritis, Non-rheumatic Aortic (Valve) Stenosis and Psychotic Disorder. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date of 7/16/19, revealed Resident #2 scored 3 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. The facility submitted an acceptable Removal Plan on 8/9/19, for the IJ. Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit. On July 9, 2019, Resident #2 was sent out to a local hospital for low Oxygen saturation. The hospital called to notify the Director of Nursing at the facility on July 9, 2019 at approximately 4:30 PM, that the resident was positive for Trichomonas. The State Agency notified the Administrator that the facility had been placed in Immediate Jeopardy at 10:25 AM, on August 7, 2019, for Failure to protect the resident due to alleged incident of abuse, Failure to report to the local law enforcement, and Failure to investigate thoroughly, once informed of the allegation and positive test results. Corrective actions: 1) An investigation was begun on July 9, 2019 at 5:00 PM, by the Administrator and the Director of	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 _____	08/10/2019

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 15 Nursing. 2) A Chart review on Resident #2 occurred by the Director of Nursing on July 9, 2019 at 4:45 PM. This review included looking for previous urinalysis and review of diagnosis. It revealed that urinalysis on June 20, 2019, indicated no Trichomonas seen. 3) On July 9, 2019, at 4:50 PM, an Emergency Quality Assurance Committee Meeting was held via conference call with the Medical Director, Administrator, Director of Nursing (DON), Registered Nurse/Infection Control (RN/IC) # 1, Registered Nurse (RN)# 2, and Licensed Practical Nurse (LPN)# 1. The Medical Director was made aware of reported positive test results. After the discussion of the positive Trichomonas test there were no changes made to any policies and procedures and Resident #2 would remain across from the nurse's station with door open when no care is being provided and every two (2) hour rounds would remain in place. 4) Resident #2's brother was called by the DON and Administrator on July 9, 2019 at approximately 5:15 PM, and informed that Resident #2 tested positive for Trichomonas, a sexually transmitted disease. 5) Staff interviews began at approximately 5:30 PM on July 9, 2019, by the DON, and were completed on July 10, 2019 at approximately 5:00 PM. Six (6) interviews were conducted - Four (4) Certified Nursing Assistants (CNA), One (1) LPN and one (1) RN. Two (2) statements by CNA's indicated a foul odor was noted when changing. CNA # 3 stated: Resident #2 "does have a strong odor to her while changing, much stronger when she had a Urinary Tract Infection. She does not	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 _____	08/10/2019

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 16 wet frequently". CNA #4 stated: "I've changes her once before when she wasn't my resident at the time and notice that she had a foul odor. I believe she had a UTI." During the interview the staff was asked if they had noticed any change in Resident #2's behavior. Their responses were negative. 6) Notification was made to the SA at approximately 6:00 PM on July 9, 2019, of a report of Resident #2 testing positive for Trichomonas. 7) The Attorney General's office was notified via eform on July 9, 2019 at 6:10 PM, of a report of Resident #2 testing positive for Trichomonas. 8) A Review of video footage occurred on July 10, 2019, by the Administrator at approximately 9:30 AM. Coverage reviewed started at July 3, 2019 at 10:00 PM, to July 9, 2019, when she was sent out. There was no unusual visitors or suspicious activity observed during the review of the video. This video footage was the only footage available for review. 9) Resident #2 returned to the facility on July 10, 2019 at 4:45 PM. Resident #74, Resident #2's roommate, and Resident #2 were interviewed after her return. Resident #74 with a BIMS score of 14 was interviewed by the DON on July 10, 2019 at approximately 5:00 PM, and her responses indicated there were no unwanted visitors for her or her roommate and no bothersome behavior or mistreatment toward them by visitors, residents, or staff. An interview by the DON and the Administrator with Resident #2 occurred at approximately 10:00 AM on July 11, 2019, and she revealed negative responses in the areas of inappropriate behavior towards her	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 _____	08/10/2019

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 17 from others, being afraid, and any unwelcome visitors. Resident #2 with a BIMS score of 3 (Brief Interview of Mental Status) stated that she was happy living here. No other Resident interviews were done at this time. 10) To protect other residents from harm, the facility provided education on July 19, 22 and July 23, 2019 on Dignity, Respect, and Abuse. Nineteen (19) of 53 CNA's, nine (9) of 22 LPN's, seven (7) of nine (9) RN's, six (6) of six (6) Housekeeping, two (2) of three (3) Laundry, two (2) of two (2) Social Services, two (2) of two (2) Business Office, two (2) of four (4) Activity, ten (10) of 13 Dietary, two (2) of two (2) Floor Techs , one (1) of one (1) Central Supply, one (1) of one (1) Medical Records, zero (0) of one (1) Maintenance, one (1) of one (1) Courtyard Director, and zero (0) of three (3) Monitor Techs were trained. 11) At 10:58 AM on August 7, 2019, the local police department was called by the Administrator. They arrived at 11:05 AM to speak with the Administrator and Director of Nursing. They were provided a copy of the facility investigation and stated they would contact us on August 8, 2019, with a report and/or request for further action. 12) Education of all employees was conducted by Registered Nurse #5 beginning on August 7, 2019 at 2:30 PM, and concluded on August 8, 2019. Topics covered included: Abuse, Neglect, and Exploitation including but not limited to: signs and systems of sexual abuse; Reporting of a Reasonable Suspicion of a Crime to local law enforcement; Reporting of Alleged Abuse and Neglect; and Investigation/Prevent/Correct Alleged Violations to including but not limited to	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 _____	08/10/2019

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 18 doing a complete investigation. The Staff educated as of August, 8 2019 at 5:00 PM are as follows: Eighteen (18) of 22 LPN's, nine (9) of nine (9) RN's, 34 of 53 CNA's, three (3) of three (3) Laundry staff, six (6) of six (6) Housekeeping staff, three (3) of four (4) Activity staff, 13 of thirteen 13 Dietary staff, two (2) of two (2) Floor Technicians, one (1) of one (1) Maintenance staff, one (1) of one (1) Medical Records staff, one (1) of one (1) Central Supply staff, two (2) of two (2) Business Office staff, one (1) of one (1) Administrator, two (2) of two (2) Social Service staff, one (1) of one (1) Courtyard Director, and one (1) of three (3) Monitor Technicians. 13) No employee will be allowed to work until they are trained on Abuse, Neglect, and Exploitation including but not limited to: signs and systems of sexual abuse; Reporting of a Reasonable Suspicion of a Crime to local law enforcement; Reporting of Alleged Abuse and Neglect; and Investigation/Prevent/Correct Alleged Violations to including but not limited to doing a complete investigation. 14) The Facility Administrator initiated a phone conference with the Nurse Practitioner at The Office of Epidemiology, Mississippi State Department of Health, on August 7, 2019 at approximately 3:00 PM to determine what type of testing of male employees needs to be done for Trichomonas. She stated the type of test would be a urine test. 15) Testing of all male employees for Trichomonas began August 8, 2019. Ten (10) of ten (10) results have returned with negative findings. 16) Ambulatory Resident #19 was tested for	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 _____	08/10/2019

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 19 Trichomonas on August 8, 2019 at approximately 1:20 PM, and the result was negative. Resident #19 was tested for Trichomonas due to having recently being observed kissing a consenting female Resident #50. Resident #19 has a BIMS score of 15 and Resident #50 has a BIMS score of 15. There were no other reports to the Administrator or DON of any other male Residents exhibiting sexual behaviors or expressions between June 20, 2019 and July 9, 2019. 17) On August 9, 2019 at approximately 8:00 AM, the facility began obtaining urine samples for Trichomonas on cognitively impaired female residents with a BIMS score of 7 and below. A total of 34 female residents tested with lab results of 34 of 34 negative for Trichomonas. 18) On August 9, 2019 at approximately 8:00 AM, the facility began obtaining urine samples for Trichomonas on all male residents that are ambulatory and/or able to transfer in or out of a wheelchair without assistance. A total of 21 male residents tested with lab results of 21 of 21 negative for Trichomonas. 19) A 100% chart audit was conducted on August 9, 2019, which focused on the most recent urinalysis and diagnosis review. The chart audit revealed no diagnosis of Trichomonas and no urinalysis results were positive for Trichomonas. 20) On August 9, 2019 at approximately 2:30 PM cognitive female Residents with a BIMS score of 8 and above were interview by RN/IC #1, RN #2, Social Service Assistant and the Courtyard Director. These interviews revealed 30 of 30 residents expressed no concerns related to potential sexual abuse.	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 _____	08/10/2019

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 20 21) The QA Committee recommended a revision of the Hourly Resident Safety Rounds documentation form that was implemented August 9, 2019 at 4:00 PM, to protect Residents from sexual abuse. The QA Committee met on August 9, 2019 at 4:00 PM, with the Medical Director (per phone), Administrator, DON, RN/IC #1. RN #2 and LPN #1 in attendance. The facility asserts that the likelihood of serious harm in this matter will be removed effective August 10, 2019. The State Agency (SA) validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ. 1. The SA validated through interviews and record review the facility conducted an investigation which began on July 9, 2019 by the Administrator and the Director of Nursing. 2. The SA validated by interviews and record review a chart review on Resident #2 occurred by the Director of Nursing on July 9, 2019. This review included looking for previous urinalysis and review of diagnosis. Interview with the DON revealed the urinalysis on June 20, 2019, indicated no Trichomonas seen. 3. The SA validated by interviews and sign in sheets on July 9, 2019, that an Emergency Quality Assurance Committee Meeting was held via conference call with the Medical Director, Administrator, Director of Nursing (DON), Registered Nurse/Infection Control (RN/IC) # 1, Registered Nurse (RN)# 2, and Licensed Practical Nurse(LPN)# 1. Interview revealed the Medical Director was made aware of reported	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 _____	08/10/2019

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 21 positive test results, no changes were made to any policies and procedures and Resident #2 would remain across from the nurse's station with door open when no care is being provided and every two (2) hour rounds would remain in place. 4. The SA validated through interviews that Resident #2's brother was called by the DON and Administrator on July 9, 2019, and informed that Resident #2 tested positive for Trichomonas, a sexually transmitted disease. 5. The SA validated through interviews and record reviews that the facility began staff interviews on July 9, 2019, by the DON and were completed on July 10, 2019. Documentation included six (6) interviews were conducted - Four (4) Certified Nursing Assistants (CNA), One (1) LPN and one (1) RN. Two (2) statements by CNA's indicated a foul odor was noted when changing. CNA #3's documented statement: Resident #2 "does have a strong odor to her while changing, much stronger when she had a Urinary Tract Infection. She does not wet frequently". CNA #4's documented statement: "I've changes her once before when she wasn't my resident at the time and notice that she had a foul odor. I believe she had a UTI." Staff had not noticed any change in Resident #2's behavior. 6. The SA validated through record review and interview that the facility notified the SA on July 9, 2019 of a report of Resident #2 testing positive for Trichomonas. 7. The SA validated through interviews and record review the facility notified the Attorney General's office via eform on July 9, 2019, of a report of Resident #2 testing positive for Trichomonas.	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 _____	08/10/2019

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 22 8. The SA validated through interviews and facility investigation review that the facility reviewed the video footage on July 10, 2019 by the Administrator, covering July 3, 2019 at 10:00 PM to July 9, 2019, when the resident was sent out. Interview with the Administrator revealed there was no unusual visitors or suspicious activity observed during the review of the video. 9. The SA validated documentation that Resident #2 returned to the facility on July 10, 2019 at 4:45 PM. Interview with administrative staff revealed Resident #74, Resident #2's roommate, and Resident #2 were interviewed after her return. Resident #74 with a BIMS score of 14 was interviewed by the DON on July 10, 2019, and her responses indicated there were no unwanted visitors for her or her roommate and no bothersome behavior or mistreatment toward them by visitors, residents, or staff. An interview with the DON and the Administrator revealed interviews with Resident #2 occurred at approximately 10:00 am on July 11, 2019, and she revealed negative responses in the areas of inappropriate behavior towards her from others, being afraid, and any unwelcome visitors. Resident #2 with a BIMS score of 3 (Brief Interview of Mental Status) stated that she was happy living here. Interview with the Administrator and DON validated that no other Resident interviews were done at this time. 10. The SA validated through interviews, sign-in sheets, and record review, that the facility provided education on July 19, 22 and July 23, 2019 on Dignity, Respect, and Abuse, with staff attendance by signature. 11. The SA validated through interview with the	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 _____	08/10/2019

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 23 Administrator that on August 7, 2019, the local police department was notified, and came to the facility. They were provided a copy of facility investigation and stated they would contact the facility with a report and/or request for further action. 12. The SA validated through interview, sign-in sheets, and record review, that education of all employees was conducted by Registered Nurse #5 beginning on August 7, 2019 and concluding on August 8, 2019. Topics covered included: Abuse, Neglect, and Exploitation including but not limited to: signs and systems of sexual abuse; Reporting of a Reasonable Suspicion of a Crime to local law enforcement; Reporting of Alleged Abuse and Neglect; and Investigation/Prevent/Correct Alleged Violations to including but not limited to doing a complete investigation. The SA validated that all staff were educated as of August, 8, 2019. 13. The SA validated through interviews that no employee was allowed to work until they were trained on Abuse, Neglect, and Exploitation including but not limited to: signs and systems of sexual abuse; Reporting of a Reasonable Suspicion of a Crime to local law enforcement; Reporting of Alleged Abuse and Neglect; and Investigation/Prevent/Correct Alleged Violations to including but not limited to doing a complete investigation. 14. The SA validated by interview with the Administrator, that the Facility Administrator initiated a phone conference with the Nurse Practitioner at The Office of Epidemiology, Mississippi State Department of Health, on August 7, 2019 to determine what type of testing of male employees needs to be done for	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 _____	08/10/2019

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 24 Trichomonas and was informed the type of test would be a urine test. 15. The SA validated by record review and interviews that the facility initiated testing of all male employees for Trichomonas beginning August 8, 2019, and ten (10) of ten (10) results returned with negative findings. 16. The SA validated by record review and interviews that the facility tested Ambulatory Resident #19 for Trichomonas on August 8, 2019, with a negative result. Interview with administrative staff revealed there were no other reports of any other male Residents exhibiting sexual behaviors or expressions between June 20, 2019 and July 9, 2019. 17. The SA validated by interviews and record review that on August 9, 2019, the facility began obtaining urine samples for Trichomonas on cognitively impaired female residents with a BIMS score of 7 and below. A total of 34 female residents tested with lab results negative for Trichomonas. 18. The SA validated by interviews that on August 9, 2019, the facility began obtaining urine samples for Trichomonas on all male residents that are ambulatory and/or able to transfer in or out of a wheelchair without assistance. A total of 21 male residents tested with lab results negative for Trichomonas. 19. The SA validated through interviews and record reviews that the facility conducted 100% chart audit on August 9, 2019, which focused on the most recent urinalysis and diagnosis review. The chart audit revealed no diagnosis of Trichomonas and no urinalysis results were	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 _____	08/10/2019

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 25 positive for Trichomonas. 20. The SA validated by interviews that on August 9, 2019, cognitive female Residents with a BIMS score of 8 and above were interview by RN/IC #1, RN #2, Social Service assistant and the Courtyard Director. These interviews revealed 30 of 30 residents expressed no concerns related to potential sexual abuse. 21. The SA validated through interviews and sign-in sheets that the QA Committee recommended a revision of the Hourly Resident Safety Rounds documentation form that was implemented August 9, 2019, to protect Residents from sexual abuse. Interview validated that the QA Committee met on August 9, 2019 at 4:00 PM with the Medical Director (per phone), Administrator, DON, RN/IC #1. RN #2 and LPN #1 in attendance. The SA validated that all corrective actions were completed as of 8/9/19, and the IJ was removed on 8/10/19.	M 500		