| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey from 9/23/19 through 9/26/19. The SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited deficiencies at F577 and F880.<br><br>The facility had a census of 143, and was licensed for 152 beds. | F 000 | | |
| F 577 SS=E | Right to Survey Results/Advocate Agency Info<br>CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must--<br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents. | F 577 | | 10/25/19 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 10/20/2019 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 577 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interviews, observations, and facility statement, the facility failed to ensure residents were aware of the location and availability of the most recent survey results, for four (4) of five (5) residents who attended the group meeting.<br><br>Findings include:<br><br>Review of the facility statement, signed by the Administrator, dated 9/26/19, revealed: One (1) of the Resident's rights is to have survey results, with plans of correction, for the past three (3) years, posted in a place accessible to residents. Per the Resident Rights, these results are in the facility at each nurse's station.<br><br>During the group meeting on 9/24/2019 at 1:30 PM, four (4) of five (5) residents did not know where the survey results were located in the facility.<br><br>During an interview, on 09/25/19 at 2:45 PM, Social Worker #1 did not know where last year's survey results were posted. Social Worker #1 stated she did not know how the residents were being educated as to where the survey results were posted.<br><br>During an interview on 09/25/19 at 2:50 PM, Activity Director #1 stated that Social Services conducts Resident Council meetings. Activity Director #1 stated she had not educated the residents on where last year's survey results were posted.<br><br>Observation on 09/25/19 at 9:30 AM, revealed | F 577 | Survey results were posted at the North, South, and Rehabilitation Unit nurses stations on September 26, 2019 by the Maintenance Director and Licensed Nursing Home Administrator.<br><br>All residents have the potential to be affected by the alleged deficient practice.<br><br>Department Heads, Registered Nurse Unit Managers, Registered Nurse Resident Care Coordinators, Registered Nurse Staff Developer, Licensed Practical Nurse Minimum Data Set Staff, and Business Office staff were informed of the location of the survey results and the regulations where the requirements of posting are located by the Licensed Nursing Home Administrator on September 26, 2019. Members of the Resident Council were informed of the locations of the posted survey results by the Activity Director on September 26, 2019 and again during their regularly scheduled Resident Council Meeting on October 14, 2019 by the Licensed Master's Social Worker.<br><br>The posting and locations of the survey results will be reviewed in the monthly Resident Council Meeting.<br><br>The Resident Council Meeting Minutes will be integrated into the Quality Assurance system via the Quality Assurance Meeting held on October 23, 2019. The Quality Assurance Committee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 577 | Continued From page 2<br>survey results were posted on the table in the front lobby. There was a sign on the wall in the South Nursing Station, that survey results are posted in the front lobby. A sign was not posted on the North Hall or on the Rehabilitation unit, indicating where survey results were posted. | F 577 | will review the meeting minutes to ensure that appropriate communication is taking place and changes are made as needed. This monitoring will be reviewed in the monthly Quality Assurance Meeting for three months. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | F 880 | | 10/25/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 3<br>persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, facility policy review, and staff interview, the facility failed to prevent the possible spread of infection, during | F 880 | The residents who were allegedly given medications touched by an ungloved hand showed no negative effects by the alleged | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 4<br>medication preparation for two (2) of five (5) nurses observed administering medications.<br><br>Findings include:<br><br>Review of the facility's "Administering Medications," policy, dated 12/2017, revealed staff should follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications.<br><br>Review of the facility's "Infection Control Guidelines for All Nursing Procedures", dated August 2015, revealed the purpose of this document is to provide guidelines for general infection control while caring for residents. The document indicated standard and transmission-based precautions are used to prevent the spread of infection. The document noted that employees must wash their hands. The document noted in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. The document noted the alcohol based hand rub is to be used before preparing or handling medications.<br><br>During an observation on 9/24/2019 at 9:15 AM, Licensed Practical Nurse (LPN) #1 prepared to administer oral medications to a resident. LPN #1 placed her ungloved right (R) index finger into a bottle of Aspirin to retrieve a tablet. LPN #1 placed the tablet with her bare hand from the bottle into the medication cup. LPN #1 placed seven (7) additional pills into the same medication cup. LPN #1 administered all of the medications from the medication cup to a resident. | F 880 | deficient practice. All residents on subsequent medication passes by Licensed Practical Nurses # 1 and 2 were administered in a manner to prevent the spread of infection.<br><br>All residents have the potential to be affected by the alleged deficient practice.<br><br>All facility nurses were inserviced on Medication Administration and Infection Control Practices by the Registered Nurse Staff Developer on September 26, 2019. Medication passes will be monitored by the Registered Nurse Resident Care Coordinators for the North and South Halls and by the Registered Nursing Staff Developer on the Rehabilitation unit twice weekly for four weeks then once weekly for four weeks with the results of this monitoring documented on a Medication Pass Audit Tool. These audits began on October 23, 2019.<br><br>Results of this monitoring will be integrated into the facility Quality Assurance system via the Quality Assurance Meeting held on October 23, 2019. The Quality Assurance Committee will review the Medication Pass Audit Tool to ensure medication passes are occurring in a manner to prevent the spread of infection and that changes are made as needed. The review of this Audit Tool will be reviewed in the monthly Quality Assurance Meeting for two months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 5<br><br>During an interview on 9/24/2019 at 9:29 AM, LPN #1 confirmed that she had retrieved the Aspirin tablet with her bare hand and put it in the medication cup for a resident. LPN #1 stated, "That was stupid, I knew I shouldn't have done that." LPN #1 stated that you should never touch a medication with your bare hands to give to a resident. LPN #1 stated that touching medications with your bare hands could cause the spread of infection.<br><br>During an observation on 9/25/2019 at 9:07 AM, LPN #2 prepared oral medications for a resident. LPN #2 placed each oral medication, from it's respective bubble pack, into the palm of her bare hand, and then into the medication cup. LPN #2 prepared a total of nine (9) oral medications in this manner. LPN #2 administered all nine (9) oral medications to the resident.<br><br>During an interview on 9/25/2019 at 9:20 AM, LPN #2 confirmed she had placed each pill, for a total of nine (9) oral medications, into her bare hand, placed the medication into the cup, and administered the medication to the resident. LPN #2 stated there could have been bacteria on her hands, and it could have spread to the resident. LPN #2 stated she had been trained on the correct way to dispense medications.<br><br>During an interview on 9/24/2019 at 11:50 AM with the Director of Nursing (DON), the DON stated that nurses should never touch the oral medications with their bare hands. The DON stated that touching medications with bare hands would be an infection control concern.<br><br>During an interview on 9/26/2019 at 11:46 AM, | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/26/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 6<br>the Director of Nursing (DON) confirmed that touching or placing medications into your bare hands is not how she would expect the nurse to prepare and give oral medications.<br><br>Review of the facility's in-service documentation records revealed LPN #1 and LPN #2 had both been trained on the steps and process to follow proper infection control techniques during medication administration. LPN #1 on 10/17/18, and LPN #2 on 9/6/19. | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING **02 - BUILDING 02**<br>B. WING _____ | **09/30/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BEDFORD CARE CENTER OF HATTIES** | **#10 MEDICAL BOULEVARD**<br>**HATTIESBURG, MS 39401** |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).<br><br>There were no LSC deficiencies cited during this survey. | K 000 | | |

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

Electronically Signed | 10/20/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | 09/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEDFORD CARE CENTER OF HATTIES | #10 MEDICAL BOULEVARD HATTIESBURG, MS 39401 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>**********<br><br>Survey conducted on 09/30/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements.<br><br>No deficiencies were cited. | E 000 | | |

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

Electronically Signed | 10/20/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.