STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255150	A. BUILDING _____ B. WING _____	10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MENDENH	925 WEST MANGUM AVENUE MENDENHALL, MS 39114

(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 The State Survey Agency (SA) conducted an annual recertification survey at the facility from 10/10/17 to 10/12/17. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F 280, F 282, F 314, F 371, and F 526. At the time of survey, the census was 58, and the facility held a license for 60 beds.	F 000		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		11/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2017

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.

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F 280	Continued From page 1 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 280		

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F 280	Continued From page 2 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure that a care plan was revised to include correct identification of pressure sores for one (1) of 15 care plans reviewed, Resident #6. Findings include: Review of "Using the care plan" policy, revised January 2015, revealed that changes in the resident's condition must be reported to the MDS assessment Coordinator so that a review of the resident's assessment and care plan can be made. Resident #6: Review of Resident #6's care plan, dated 10/10/17, revealed care plans regarding the resident's skin integrity. The care plan, dated 8/4/16, revealed an original problem for risk of skin breakdowns related to a healed Stage Four (4) pressure ulcer (PU). The care plan, initiated 1/5/17, revealed an abrasion to the left sacral	F 280	*Disclaimer: Bedford Care Center of Mendenhall, LLC acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and regulations. Please accept this Plan of Correction as our credible allegation of compliance with rules and regulations. Bedford Care Center of Mendenhall's response to this statement of deficiencies does not denote agreement with the stated deficiencies nor does it constitute admission that any deficiency is accurate. * The comprehensive care plan was revised on Resident #6 to include correct staging and complete assessment of wound/pressure ulcer, On 10/13/17 by the MDS Nurse. The Medical Director and the DON observed wounds on residents noted during survey process to ensure	

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F 280	Continued From page 3 area. The care plan with an onset date of 08/28/17, revealed a Stage 2 pressure ulcer on the sacrum. Review of the Weekly Full Body Skin Observations, dated 8/28/17 and 9/4/17 revealed a stage 2 to the sacrum. The reports dated 10/2/17 and 10/10/17, revealed an abrasion to the sacral area. Observation, with RN #1, on 10/11/17 at 3:30 PM, revealed Resident #6 had a Stage 2 PU on the sacral area with measurements of 0.1 centimeter (cm) x 0.1 cm. This was the only wound observed for Resident #6. During an interview on 10/12/17 at 3:00 PM, Licensed Practical Nurse (LPN) #1/ MDS Coordinator/ Care Plan Coordinator confirmed that she developed and revised the care plans based on the nurse's documentation and the weekly body audits completed by the Registered Nurses (RN). LPN #1 confirmed the body audit documentation and care plan were not consistent. Interview with RN #3, on 10/12/17 at 11:57 AM, revealed the Stage 2 PU and the abrasion for Resident #6's sacral area was always the same wound. She stated the wound was first an abrasion, then a Stage 2 and then back to an abrasion. She stated that she had treated this same wound and had documented the weekly body observation reports. A review of the facility's face sheet revealed the facility admitted Resident #6 on 03/29/16, with a diagnosis to include Chronic Obstructive Pulmonary Disease and a Stage 4 Pressure Ulcer to the Coccyx.	F 280	correct identification and staging of wounds. Care plan was updated to reflect current problem, goal and intervention according to facility policy. *All residents have the potential to be affected by the deficient practice. * An in-service was held on 10/18/17 by R.N. certified in wound care and staging of wounds, with all facility registered nurses addressing wound care assessment and staging of wounds and correctly documenting in care plan. *The RCC/QA RN will audit weekly the wound documentation for accuracy and consistent documentation, for one month beginning 10/18/17. These audits will be reviewed in the Weekly Wound Meeting by Interdisciplinary Team. *Plan of Correction will be integrated into the Quality Assurance system at the next monthly Q.A. meeting and audit findings will be reviewed quarterly to ensure POC is being followed.	

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F 280	Continued From page 4 A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/17, revealed the Resident's Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to follow the care plan for pressure ulcer/wounds for three (3) of 15 care plans reviewed; Residents #2, #4, and #5. Findings include: A review of the facility's policy titled, "Care Plans-Comprehensive", dated March 2017, revealed the Nurse Supervisor uses the care plan to direct care provided by the Certified Nurse Assistance (CNA) and nurses daily. The CNA's are responsible for reporting to the Nurse Supervisor any changes in the resident's condition. Review of the facility policy titled "Using the Care	F 282	*The comprehensive care plan has been revised on Residents #2,#4,#5, and #6 addressing wound care/pressure ulcer and consistent documentation according to facility policy. On 10/12/17, the Medical Director and the DON observed wounds on Resident #2, Resident #4, Resident #5, and Resident #6 to ensure correct staging and identification of wound. *All Residents have the potential to be affected by the deficient practice. *An in-service was held on 10/18/17 by R.N. certified in wound care and staging of wounds, with all facility registered nurses, addressing wound care assessment and staging of wounds and	11/30/17

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F 282	Continued From page 5 Plan", dated August 2006, revealed that documentation must be consistent with the Resident's Care Plan. The facility policy noted that other facility staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the Minimum Data Assessment (MDS) Coordinator. Resident #4 Review of Resident #4's Care Plan revealed a history of a boggy area to left heel with an onset date 08/22/17, and a Goal & Target date of 11/23/17. The Interventions included: Weekly observation per Registered Nurse (RN) and monitor skin daily during routine activities of daily living (ADL). An additional care plan, initiated 8/25/17, revealed a risk for skin breakdown due to Diabetes Mellitus and Occluded anterior tibial artery bilaterally. Interventions included to observe for changes in skin color or texture, report to MD if there is an increase in size and follow up as indicated. An observation on, 10/11/17 at 2:35 PM, revealed RN #1 provided wound care to Resident #4. An observation at the conclusion of the wound care of the left heel, revealed Resident #4's wound (pressure ulcer) had a foul odor, redness, drainage with an area measuring 4 centimeters (cm) wide x 4 cm in length. A discoloration of the wound was noted with a black area in middle, yellowish in color on outer edge and redness on the outer edge. A record review titled "Weekly Full Body Skin Observation", revealed Registered Nurse #2 assessed Resident #4 on 10/10/17 with bilateral arterial foot wounds being dressed per nursing staff. There was no documented measurements	F 282	correctly documenting in care plan. *RCC/QA R.N will audit weekly the wound documentation for accuracy and consistent documentation, for one month beginning 10/18/17. These audits will be reviewed in the Weekly Wound Meeting by Interdisciplinary Team. *Plan of Corrections will be integrated into the Quality Assurance System at the next monthly Q.A meeting and audit findings will be reviewed quarterly to ensure POC is being followed.	

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F 282	Continued From page 6 or a description of the wound. There was no "Weekly Wound Assessment" by the RN for the left heel. An interview on 10/11/17 at 6:00 PM, with RN #2, confirmed she did not remove the dressing on Resident #4's heel when she did the body audit on 10/10/17. She also revealed, she had not done a complete body audit by assessing the whole body. RN #2 confirmed not following the care plan (by not assessing the actual wound). An interview, on 10/11/17 at 8:00 AM, with the Minimum Data Nurse (MDS), revealed she prepared and updated the resident's care plan per what the nurses put in their notes. Review of a physician's progress note, dated 10/12/17, revealed the right heel had a small lesion from pressure, and the left heel had a large lesion which started out as a diabetic ulcer, complicated by vascular insufficiency and location of pressure points. Review of the facility's Face Sheet revealed, the facility re-admitted the resident on 7/5/17. Resident #4's diagnoses included Diabetes Mellitus, Non-Alzheimer's Dementia, and Pressure Ulcers. Review of the MDS with an Assessment Reference Date (ARD) of 07/12/17, revealed Resident #4 had a Brief Interview of Mental Status (BIMS) score of 11, indicating the resident had moderately impaired cognition. Section M for pressure ulcer risk and information was blank. Resident #2: Review of Resident #2's care plan, dated 4/10/17,	F 282		

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F 282	Continued From page 7	F 282		

revealed a risk for skin breakdown, and another with an Unstageable pressure ulcer (PU) on the Coccyx. Interventions included to observe for changes and follow up as indicated. Further interventions revealed the RN was to monitor the skin weekly.

Observation of wound care on 10/11/17 at 11:20 AM, with RN #1, revealed a pressure wound located on Resident #2's coccyx area. The wound measured 2.0 centimeters (cm) in length, 1.5 cm in width and 0.75 cm in depth.

Review of the last Weekly Wound Assessment, dated 9/25/17, revealed a stage 4 pressure ulcer to the sacrum which measured 2.0 cm length with 1.5 width and 0.75 depth of the ulcer. No further assessment was documented.

Interview with RN #1 at 10/11/17 at 11:30 AM, revealed he thought it had been several months since the wound care treatment orders had been changed, the NP looked at the wounds monthly. RN #1 stated he was trying to catch up the weekly skin assessments, that he'd been out a couple of weeks and the weekly assessments had not been done for Resident #2, per care plan.

Interview on 10/12/17 at 8:30 AM, with the Nurse Practitioner, revealed she tried to look at the wound monthly but would look at the wound more often if the nurses asked her to or if it had changed.

Review of the face sheet revealed the facility admitted Resident #2 on 3/27/17, with diagnoses which included a fracture of the hip, Parkinson's, and Diabetes Mellitus. Resident #2 had an Unstageable Pressure Ulcer identified on admit to

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F 282	Continued From page 8 the Coccxy. Review of the MDS with an ARD of 9/25/17, revealed Resident #2's BIMS score of 4, indicating severe cognitive impairment. Resident #5: Review of Resident #5's care plan, initiated 8/3/17, revealed, "Resident has Unstageable pressure ulcer on LEFT heel". Approaches included to monitor for signs and symptoms of infection and report to MD with follow up as indicated. Additional approaches were to reduce pressure with heel protectors and use of pressure reducing mattress on the bed. Observation of wound care to the left heel on 10/11/17 at 1:45 PM, with RN #1, revealed Resident #5 lying in bed on his back. Resident #5's heels were not elevated off the mattress, and he was wearing a pair of socks, not heel protectors, per care plan. A wound was located on the back portion of Resident #5's left heel. There was a dressing in place and removed by RN #1, which revealed a circular shaped pressure ulcer, covered with dark black tissue with redness surrounding the portion of the left heel. The wound measured approximately 1.0 cm length by 1.5 cm width, with undetermined depth due to the eschar. Interview on 10/11/17 at 1:45 PM, with RN #1, revealed the wound was considered as an "arterial ulcer" and Resident #5 had been admitted with the wound present. He confirmed the left heel was not elevated and the resident had no heel protector in place. The Nurse Practitioner (NP) was present during the wound observation and stated it would be a good idea to	F 282		

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F 282	Continued From page 9 float the heels. Interview on 10/12/17 at 10:30 AM, with Licensed Practical Nurse #1, who was the Care Plan and Assessment Nurse, stated she used nursing documentation for the MDS and Care plan. She stated she coded the MDS and initiated the care plan for a pressure ulcer because there was no supporting documentation of an arterial ulcer for Resident #5. She confirmed the resident's care plan wasn't followed if heel protectors weren't used. Review of the facility's face sheet revealed, the facility admitted the resident on 10/4/17. Resident #5's diagnoses included Chronic Obstructive Pulmonary Disease and Diabetes Mellitus Type 2. Review of the MDS with an ARD of 9/18/17, revealed Resident #5 had a BIMS score of 13, which indicated he was cognitively intact.	F 282		
F 314 SS=E	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		11/30/17

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F 314	Continued From page 10 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to consistently and accurately assess, stage, and identify pressure ulcers/wounds for four (4) of seven (7) residents reviewed; Resident #2, #4, #5, #6 Findings include: A facility policy titled "Pressure Ulcer Treatment", dated January 2017, revealed the purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers by assessing the resident and the current status of the pressure ulcer(s). Resident #4: An observation on 10/11/17 at 2:35 PM, revealed Registered Nurse #1 performed wound care on Resident #4. While cleaning the left heel of Resident #4, a pressure wound was noted, which measured 4 centimeters (cm) X (by) 4 cm length with a foul odor, yellow drainage, and dark black area in middle, with redness on the outer edge of the wound was noted. An interview on 10/11/17 at 2:50 PM, with RN #1, confirmed Resident #4's wound had a foul odor, black colored area in middle of wound, drainage, and redness on outer edge of wound. RN #1 confirmed he reported to the Director of Nursing	F 314	* On 10/12/17, the Medical Director and DON observed wounds on Residents #2, #4, #5 and #6 that were noted during survey process to ensure correct identification and staging of wounds. Care plans were reviewed and updated on 10/13/17, by the MDS Nurse to reflect current problems, and interventions according to facility policy. *All Residents with wounds/pressure ulcers have the potential to be affected by the deficient practice. On 10/12/17 The Medical Director and DON observed wounds on Residents #2, #4, #5, and #6 that were noted during the survey process, No other Residents were identified. *An in-service was held on 10/18/17 by R.N. certified in wound care, addressing pressure ulcer risk, treatment and prevention of wound/pressure ulcers, with facility registered nurses. Education for identification, staging, and documentation will be on-going by the Staff Development R.N. *RCC/QA RN will audit weekly the wound documentation for accuracy and consistent documentation. These audits will be reviewed in the Weekly Wound	

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F 314	Continued From page 11 (DON) and the Family Nurse Practitioner (FNP) that the left heel wound had worsened. RN #1 stated "the DON was going to email the wound care nurse at corporate to come assess the wound". RN #1 stated "I don't have a lot of experience in wounds and I need some help with this wound". RN #1 denied of having any additional class room training in wound assessment. RN #1 stated the only training he had received was "on the job" training. Record review of "Weekly Full Body Skin Observation" reports, revealed Registered Nurse (RN) #2 assessed Resident #4's skin with inconsistency and with no measurements or description of the wounds. The assessments were documented on the following dates with the following results: 7/13/17-Blister right lateral heel. Chronic. No measurements documented. 7/19/17-Blister on lateral right heel. Goes to wound care every week. Other: Arterial. No measurements/description. 7/26/17-All areas observed: "N/A" (non-applicable) documented. 8/2/17-All areas observed: N/A documented. 8/9/17-Wound to right foot (heel), goes to wound care on Fridays. No measurements/description. 8/16/17-Wound on right foot related to arterial flow, goes to wound care on Fridays. No measurements/description. 8/23/17-Wound on foot, goes to wound care on Friday. Chronic. No measurements or description. 8/30/17-N/A is documented. 9/6/17-N/A is documented. 9/13/17-Still has right foot wound-dressing applied Monday, Wednesday and Friday. No measurements or description documented.	F 314	Meeting by Interdisciplinary Team. *Plan of Correction will be integrated into the QA System at the next monthly meeting. Audit findings will be reviewed quarterly to ensure POC is being followed.	

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F 314	Continued From page 12 9/20/17-Right heel is trying to close and has eschar or scab and continues to improve, left heel has a split. Both are being dressed per MD orders. The wounds were documented as "Chronic". There were no measurements of the wounds. (This is the first mention of the left heel observation). 9/27/17-Right heel eschar is continuing to heal. Left heel has no change. No measurements or descriptions were documented. 10/4/17-Right heel arterial wound healing and left heel arterial wound healing. No measurements or descriptions documented. 10/10/17-Bilateral arterial foot wounds being dressed per nursing staff. No measurements or description of the wounds. Review of Resident #4's current care plan, revealed a problem, "Boggy area to left heel", initiated 8/22/17. Interventions included weekly observations by the RN. A record review titled "Physician's Monthly Progress Notes", dated on 9/5/17, revealed sores on heels slowly improving, pain with standing. Further review of the progress notes, dated 10/12/17, revealed a left heel large lesion. Lesions from pressure with nice clean healthy margins centrally, there is large soft yellow Eschar with small brown discoloration-pliable, not black and not hard, will need debridement of Eschar. The note documented the lesions began as diabetic ulcers. Review of the October 2017 Physician's Orders revealed an order for Resident #4, initiated 7/8/17, to apply Promogram to the right heel bed and place foam with a hole cut out for off loading, place gauze over foam and secure with Onform	F 314		

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and tape. Change three (3) times weekly and as needed.

Review of Resident #4's October 2017 Physician's Orders revealed an order for Aquacel foam dressing to the left heel for prevention due to soft/boggy heel, initiated 8/31/17. Orders dated 10/12/17, revealed to discontinue the treatment to the left heel and clean the area with normal saline and pat dry. Paint ulcer to left heel with Betadine. Cover area with Aquacell extra AG every day. There was no documentation of the appearance of Resident #4's left heel from 8/31/17 through 10/11/17, with the exception of a weekly skin note on 9/20/17 that documented the left heel had a "split".

An interview on 10/11/17 at 4:15 PM, with the DON, revealed no email was sent to the wound care nurse at corporate to come and observe Resident #4's left heel wound. The DON stated "I did not know about the left heel wound at all". The DON confirmed the only training the staff receives is a formulary on wounds. The DON confirmed all residents were to get weekly body audits per RN's. (The formulary was not provided during survey).

An interview on 10/11/17 at 6:00 PM, with RN #2, confirmed she did routine body audits on Resident #4 and that she had not removed the dressing on Resident #4's heel when she did the body audit on 10/10/17. She stated that she goes by what the Certified Nursing Assistants (CNAs) tell her. RN #2 stated she had not done a complete body audit by assessing the whole body. RN #2 stated no one had told her Resident #4's wound had worsened. RN #2 revealed the importance of full body audits are to look for any

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F 314	Continued From page 14 new or worsening areas on the body. An interview on 10/12/17 at 8:35 AM, with the Family Nurse Practitioner (NP), revealed she had not assessed the wound on Resident #4's left heel recently. An interview on 10/12/17 at 11:08 AM, with CNA #2, revealed it is their responsibility to inform Supervisors of any redness or change in skin found during care of residents, they don't usually take bandages off to look. Review of the facility's Face Sheet revealed, the facility admitted the resident on 10/12/13, with a re-admit date of 7/5/17. Resident #4's diagnoses included Diabetes Mellitus, Non-Alzheimer's Dementia, and Pressure Ulcers. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 07/12/17, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident's cognitive status was moderately impaired. Resident #6: An observation of the wound care provided to Resident #6 on 10/11/17 at 3:30 PM, by RN #1, revealed that Resident #6 had a 0.1 cm x 0.1 cm x 0.0 cm open area located on the sacrum. RN #1 measured a reddened area that was 4.5 cm x 3.0 cm x 0.0 cm that surrounded the open area. RN #1 completed the wound care per the doctor's orders with no concerns. No other area or wound treatments were provided. During an interview on 10/11/17 at 4:10 PM, RN #1 stated that the location of the Stage 2 pressure ulcer was on the same location as the	F 314		

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F 314	Continued From page 15 healed Stage 4 pressure ulcer that had previously been healed in July. RN #1 stated that this was the only area or wound that he had been treating for Resident #6. RN #1 also stated that the current wound was actually a re-opened area of the Stage 4 that Resident #6 had been admitted with. RN #1 stated that he was unaware of any other treatments or wounds for this resident. During a review of the facility's report titled, "Orders by Order Code, dated 10/10/17, provided by the Director of Nursing (DON) as a wound care report, revealed that Resident #6 had an abrasion to the left of the sacrum, and a sacral wound. A review of the Medication Administration Record (MAR) for August, September, and October, 2017, revealed treatments for a sacral wound to be done every other day and a treatment for an abrasion to left of the sacrum to be done every three (3) days. A review of the facility's documents titled, "Weekly Full Body Skin Observation", completed by RN #3, on the following dates and times revealed information about Resident #6's skin audits, which failed to identify any measurements or description of the pressure ulcer or abrased area to the coccyx: On 08/07/17-Resident #6 had an irritated area with abrasion to the coccyx. No other wounds were identified. On 08/14/17-Resident #6 had an irritated area with an abrasion to the coccyx. No other wounds were identified. On 08/28/17-Resident #6 had a Stage two (2) to the sacrum. No other wounds were identified.	F 314		

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F 314	Continued From page 16 On 08/28/17-Resident #6 had a wound identified as a Stage 2, chronic wound, located on the sacrum. No other wounds were identified. On 09/04/17-Resident #6 had a Stage 2 to the sacrum. No other wounds were identified. On 09/11/17-Resident #6 had a healing abrasion to the sacrum. No other wounds were identified. On 09/18/17-Resident #6 had a healing abrasion to the sacrum. No other wounds were identified. On 09/25/17-Resident #6 had an abrasion to the sacrum. No other wounds were identified. On 10/02/17-Resident #6 had an abrasion to the sacrum. No other wounds were identified. On 10/10/17-Resident #6 had a healing abrasion to the sacrum. No other wounds were identified. An interview with the DON on 10/12/17 at 10:50 AM, confirmed that a sacral wound and an abrasion to the left sacrum was listed on the wound report that she provided on 10/10/17. The DON confirmed that there is only one (1) wound documented on RN #3's Weekly Full Body skin observations for 8/28/2017, 09/04/2017, 09/11/2017, 09/18/2017, 09/25/2017, 10/02/2017, and 10/10/2017. The DON stated that there should have been two (2) wound areas identified as being treated listed on the weekly skin observations documented by RN #3. The DON stated the weekly skin observation did not reflect the resident's actual wounds being treated during that time frame. The DON also stated that the MARs showed two (2) separate areas as being treated. The DON stated that she was sure that there were two (2) separate areas being treated previously and that on 10/10/17, she had the area to the left sacrum discontinued because it had healed. The DON stated that the treatment would continue for the Stage 2 pressure ulcer to the sacrum.	F 314		

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F 314	Continued From page 17 In a telephone interview, on 10/12/17 at 11:57 AM, RN #3 confirmed that she was the RN who had completed the weekly skin observation documentation on Resident #6 on 8/28/17, 09/04/17, 09/11/17, 09/18/17, 09/25/17, 10/02/17, and 10/10/17. RN #3 stated that she had only been assessing and treating one (1) wound. RN# 3 also stated that the abrasion and the Stage 2 pressure ulcer was the same wound. RN #3 stated that the abrasion became a Stage 2 pressure ulcer on 08/28/17. RN #3 stated the Stage 2 pressure ulcer remained for the 09/04/17 weekly full body skin observation. Then, RN #3 stated that the Stage 2 pressure ulcer had healed prior to the weekly full body skin observation she documented on 09/11/17. RN #3 stated that the current abrasion, the healed Stage 2 pressure ulcer, and the healed Stage 4 pressure ulcer were all the same wound that she had been documenting on the weekly full body skin observation documentation. RN #3 stated that she was not aware of another abrasion to the left sacrum. A review of the facility's face sheet revealed the facility admitted Resident #6 on 03/29/16, with diagnoses to include Chronic Obstructive Pulmonary Disease and a Stage 4 Pressure Ulcer to the Coccyx. A review of the Quarterly MDS with an ARD of 07/03/17, revealed Resident #6's BIMS score of 14, indicating no impaired cognition. Section M identified no area of pressure ulcer/wound. Resident #5: Observation of wound care, with RN #1, on 10/11/17 at 1:45 PM, revealed a wound located on the back portion of Resident #5's left heel.	F 314		

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Resident #5 was in his bed and lying on his back. Both of his feet were resting on the mattress. He had on cotton socks and a dressing to the left heel. RN #1 removed the dressing from the left heel and revealed a pressure wound, which was circular shaped and covered with dark tissue. The surrounding skin on the left heel was red and intact. The dark skin measured approximately 1.0 cm length by 1.0 cm width. Unable to measure depth because of the black/red tissue. RN #1 confirmed the resident did not have heel protectors in place, nor were the feet elevated. The NP, who was also present, stated, that floating the heels would be a good idea.

Review of the "Weekly Wound Assessment", dated 7/18/17, revealed the wound on the left heel was identified on 7/17/17. The cause of the wound was listed as pressure, Stage 2, with documented measurements of 1.8 cm x 1.5 cm x 0.1 cm. Completed by RN #3.

Review of the "Weekly full body skin observation" report for 8/31/17, documented Resident #5's left heel wound as an arterial stasis wound and no measurements were listed. Completed by RN #1.

The Nursing Progress Note dated 8/4/17, documented the wound on Resident #5's left heel as a Stage 2 pressure ulcer. A Nursing Progress Note dated 9/15/17 and 9/20/17, included documentation of the left heel as an unstageable pressure ulcer.

An "Orders by Order Code" document with a handwritten, "Wound Report" listed the wound on Resident #5's left heel as unstageable and circulatory.

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F 314	Continued From page 19 Review of the care plan with an effective date of 9/20/17, listed Resident #5's wound as an Unstageable Pressure Ulcer on the left heel. Interview with RN #1 revealed Resident #5's wound was termed an "arterial ulcer" and was present on admission. Interview on 10/12/17 at 9:50 AM, with Staff Development Nurse #2, revealed Resident #5's wound was a stasis ulcer when the resident returned from a hospital stay. Interview on 10/12/17 at 10:30 AM, with Licensed Practical Nurse (LPN) #1/MDS Assessment Nurse, revealed she had coded Resident #5's wound as a pressure ulcer from the RN documentation, because she had no supporting evidence to determine the wound was arterial. Review of the facility face sheet revealed the facility re-admitted Resident #5 on 10/4/17, with diagnoses which included Peripheral Neuropathy, Chronic Obstructive Pulmonary Disease, and Pressure Ulcer. Review of the MDS, with an ARD of 9/18/17, revealed Resident #5 had a BIMS score of 13, which indicated he was cognitively intact. Section M coded Resident #5 with one (1) unstageable pressure ulcer which measured 1.0 centimeter length by 1.5 centimeter width with eschar. Resident #2: Observation of wound care on 10/11/17 at 11:20 AM, with RN #1, revealed a circular shaped pressure wound on Resident #2's coccyx area which measured 2.0 cm in length, 1.5 cm in width	F 314		

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and 0.75 cm in depth. At the conclusion of wound care, RN #1 revealed he had no formal wound care training and had been calling the wound a "Stage 2". RN #1 stated the NP observed wounds monthly.

Review of the "Weekly Wound Assessment" reports, documented by RN #1, revealed the following documentation related to Resident #2's pressure wounds:

On 9/4/17- A pressure ulcer, Stage 2 on the sacrum, with measurements 1.75 cm x 1.5 cm x 0.5 cm and undermining of 0.5 cm at 12 and 3 o'clock.
On 9/11/17- A stage 2 on the sacrum, with measurements 1.5 cm x 1.5 cm x 0.5 cm with undermining and tunneling of 0.5 cm at 12 and 3 o'clock.
On 9/18/17-A stage 2 on the sacrum, with measurements 1.0 cm x 1.25 cm x 0.5 cm, with undermining of 0.5 cm at 12 and 3 o'clock.
On 9/25/17-A stage 4 on the sacrum, with measurements 2.0 cm x 1.5 cm x 0.75 cm with undermining of 0.5 cm at 5 and 6 o'clock.
On 10/02/17-A stage 4 on the sacrum, with measurements 2.0 cm x 1.5 cm x 0.75 cm with undermining of 0.5 cm at 5 and 6 o'clock.
On 10/11/17- stage 4 on the sacrum, with measurements 2.0 cm x 1.5 cm x 0.75 cm with undermining of 0.5 cm at 5 and 6 o'clock.

Interview on 10/11/17 at 4:25 PM, with the DON, revealed RN #1 had no additional wound training and the facility and staff followed a formulary for wound determination. The DON stated the wound on Resident #2 was a "Stage 4".

Interview on 10/12/17 at 8:35 AM, with the NP,

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F 314	Continued From page 21 revealed the coccyx wound for Resident #2 was a "Stage 3". The NP stated she tried to look at the resident's wound monthly and when the nurses asked, or if there is a change. Record review of the physician's progress note, dated 10/12/17, revealed Resident #2's wound was a Stage 4 and was continuing to heal. Review of Resident #2's care plan, initiated 4/10/17, revealed an unstageable pressure ulcer to the coccyx. Review of the facility's face sheet revealed the facility admitted Resident #2 on 3/27/17. Her diagnoses included Fracture of the left femur and Parkinson's. Review of the MDS with an ARD of 9/25/17, revealed Resident #2 had a BIMS score of 4, which indicated severe cognitive impairment. Section M for Skin Conditions was coded as one (1) unstageable pressure ulcer, present on admission, which measured 1.0 cm x 1.3 cm, x 0.5 cm, with no documented stage 2, 3, or 4 ulcers. A formulary for wounds was not presented for review during this survey. An In-service, dated 5/17/17, titled "Pressure Ulcers", revealed the DON and RN #2, had attended the In-service related to reducing the risk and managing care of pressure ulcers.	F 314		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3)	F 371		11/30/17

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F 371	Continued From page 22 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to utilize hair covering for two (2) of three (3) kitchen observations. Findings include: A facility policy titled, "Personnel Adherence to Sanitary Procedures", dated 2/12, noted under Policy Interpretation and Implementation: (1a). "Hair nets or approved hats, covering all of the hair, must be worn at all times while on duty".	F 371	* As of 10/13/17, all Dietary employees are following the facility policy of sanitary procedures utilizing hair nets or approved hair covering. *All Residents have the potential to be affected by the deficient practice. * In-services were held on 10/12/17 and 10/13/17 by the DON with all Dietary employees addressing sanitary procedures for using hair nets or hair	

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F 371	Continued From page 23 An observation in the kitchen area, on 10/10/17 at 9:40 AM, revealed Dietary Manger (DM) #1 storing dishes on shelves. The DM was not wearing a hair covering during this process. Observation in the kitchen area, on 10/11/17 at 8:10 AM, revealed DM #1 preparing coffee and had no hair covering during this process. An interview on 10/11/17 at 3:20 PM, with DM #1, confirmed she was not wearing hair nets on these two (2) different observations. DM #1 stated she was supposed to wear nets or hair covering at all times while in the dietary area and realized this is a sanitary issue. An interview on 10/12/17 at 8:18 AM, with Registered Dietitian (RD) #2, confirmed hair covering should been worn at all times while in the dietary department. RD #2 stated if not worn, hair can fall out and get in the food.	F 371	covering at all times while on duty according to facility policy. An in-service was also held on 11/20/17 by the Infection Control RN, with all dietary employees addressing Sanitary procedures for using hair nets or hair covering at all times while on duty. Staff is aware of hair net containers located outside of each entrance of the dietary department. * Beginning 10/12/17, QA nurse will monitor dietary department weekly for one month to ensure that compliance with hair net use is being followed according to facility policy. QA nurse will report findings to the quarterly QA meeting. * Plan of Correction will be integrated into the quality assurance system at the next monthly QA meeting and audit findings will be reviewed quarterly to ensure POC is being followed.	
F 526 SS=D	Hospice CFR(s): 483.70(o)(1)-(4) (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a	F 526		11/30/17

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F 526	Continued From page 24 Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.	F 526		

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	255150	A. BUILDING _____ B. WING _____	10/12/2017

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F 526	Continued From page 25 (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are	F 526		

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F 526	Continued From page 26	F 526		

necessary for the care of the resident's terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

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F 526	Continued From page 27 The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's	F 526		

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F 526	Continued From page 28 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to establish, and assign clear duty, a facility Hospice coordinator. This affected one (1) of 59 residents in the building, Resident #10. Findings included: A review of the facility policy titled, "Hospice Program", dated August 2017, revealed that the facility will designate the Director of Nursing (DON) as the Hospice Coordinator for the facility. Review of the letter presented by the facility administrator on 10/11/17, dated 10/10/17,	F 526	* The Director of Nurses is aware that she is the designated Hospice Coordinator for the facility, per letter dated 10/10/17. * All Residents receiving Hospice service have the potential to be affected by the deficient practice. * The DON and facility staff have been in-serviced by the Staff Development RN on 10/12/17, addressing Hospice services and the DON as the facility coordinator.	

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F 526	Continued From page 29 revealed that the facility's DON is the Hospice Coordinator for the facility. During an interview, on 10/10/2017 at 10:05 AM, the DON stated that the facility did not have anyone assigned as a Hospice coordinator. The DON stated, "We all just kind of do it when someone is admitted to Hospice". The DON stated that the facility's Social Worker is also involved with any Hospice admissions. During an interview, on 10/11/2017 at 4:15 PM, LPN #1 stated, "The facility doesn't have a Hospice Coordinator, per se, we all help with Hospice." Review of physician's orders, revealed Resident #10 was admitted to Hospice on 6/8/17, related to Chronic Obstructive Pulmonary Disease.	F 526	* The facility Hospice coordinator will communicate with the Hospice representative and Hospice Medical Director in the care planning process for Residents receiving Hospice services and will report to the Interdisciplinary team any changes in Hospice Resident care monthly and as needed. *Plan of Correction will be integrated into the QA system at the next monthly meeting. Any changes will be reviewed quarterly to ensure POC is being followed.	

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	255150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/12/2017**

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K 000	INITIAL COMMENTS 42 CFR 438.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect corridors as per NFPA 101 Chapter 19 3.6.1. This deficiency affected one (1) of five (5) smoke compartments and zero (0) of the residents in the facility on the day of survey. Findings include: Observations made on October 12, 2017 at 11:02 AM revealed the Detergent Room was open to the corridor but lacked a hard wired smoke detector. The Detergent Room was not in a patient sleeping area but was along a required means of egress.	K 347	Disclaimer: Bedford Care Center of Mendenhall, LLC acknowledges receipt of the Statement of Deficiencies and Proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and regulations. Please accept this Plan of Correction as our credible allegation of compliance with rules and regulations. Bedford Care Center of Mendenhall's response to this statement of deficiencies does not denote agreement with the stated deficiencies nor does it constitute admission that any deficiency is accurate. *A hard wired smoke detector has been installed at the entrance of laundry room that is located to an open corridor.	11/10/17

FIRE SAFETY Received NOV 28 2017 MSDH-HFLC & CONSTRUCTION

11-28-17 Accepted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2017

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.

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K 347	Continued From page 1	K 347	* All residents have the potential to be affected by the deficient practice. *A routine check was made of facility to ensure that hard wired smoke detectors are present in areas considered means of egress. *Maintenance Supervisor will report any concerns to interdisciplinary team to ensure that facility is in compliance with hard wired smoke detectors. * Plan of Correction will be integrated into the quality assurance system at the next monthly QA Meeting and reviewed to ensure POC is being followed.	