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
	64ME	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

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M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from 10/10/17 to 10/12/17, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M615 and M815. At the time of survey, the census was 58, and the facility held a license for 60 beds.	M 000		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II 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	M 615	*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 an 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. * On 10/12/17, the Medical Director and	11/30/17

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

Electronically Signed | 11/17/17

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M 615	Continued From page 1 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 (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.	M 615	DON observed wounds on Residents #2, Resident #4, Resident #5, and Resident #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 to have wound/pressure ulcers. * An in-service was held on 10/18/17 by R.N. certified in wound care, addressing pressure ulcer risks, treatment and prevention of wound/pressure ulcers,with all facility registered nurses. Education for identification, staging, and documentation will be ongoing 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 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	

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M 615	Continued From page 2 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. 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	M 615	is being followed.	

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M 615	Continued From page 3 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 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	M 615		

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M 615	Continued From page 4 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 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.	M 615		

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M 615	Continued From page 5 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 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	M 615		

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M 615	Continued From page 6 #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. 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	M 615		

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M 615	Continued From page 7 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. 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	M 615		

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M 615	Continued From page 8 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. 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.	M 615		

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M 615	Continued From page 9 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. 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,	M 615		

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M 615	Continued From page 10 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 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	M 615		

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M 615	Continued From page 11 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, 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.	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	64ME	A. BUILDING: _____ B. WING _____	10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 615	Continued From page 12 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.	M 615		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II 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". 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.	M 815	* 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 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	11/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 815	Continued From page 13 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.	M 815	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.	