| 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 _____ | C 12/04/2018 |

| 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>CI MS #15548 & CI MS #15563<br><br>The State Agency (SA) conducted a partial extended survey for Complaint Investigation (CI) MS #15548, from 11/26/18 to 12/4/18. The SA substantiated the complaint for elopement, but did not substantiate other concerns of Quality of Care/Abuse in the complaint. During the survey, it was determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited regulatory deficiencies.<br><br>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care that began on 9/30/18, when the facility failed to provide adequate assessment and supervision for a confused, demented resident, with a past history of exit-seeking behaviors. Resident #4 eloped from the facility's front door on 9/30/18, assisted by a visitor, after attempting to exit by herself, and was found by another visitor. Resident #4 was assessed by RN #1 with no injury. There were no physical signs on the door to alert visitors of wandering residents. The Receptionist, responsible to monitor the door to ensure residents did not exit the facility without supervision, was observed on video looking at her cell phone and was not aware the resident exited the building. The street was approximately 11 steps from the front door. The sidewalk in front of the building where Resident #4 was found, was approximately 11 steps to the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled down the sidewalk, in front of the North Hall door facing the front of the building, and was approximately 34 | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/28/2018 |

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 _____ | C 12/04/2018 |

| 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 | Continued From page 1<br>steps from the front door when she was found by the daughter of another resident. Resident #4 had a history of exit seeking behaviors and was care planned for every (Q) One (1) hour visual checks by the staff and care planned for secured exit doors. The facility Administration did not report the elopement and lack of supervision of Resident #4 to the State Agencies as required.<br><br>The failure to provide supervision and follow the care plan for Resident #4, a demented resident with a history of exit-seeking behavior, resulted in the resident's elopement from the facility and placed this resident and other demented residents, at risk for elopement, in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>On 11/29/18 at 3:48 PM, the SA notified the facility's Administrator of the IJ and SQC.<br><br>The IJ and SQC existed at:<br>42 CFR(s) 483.12 (c)(1)(4)-Reporting of Alleged Violations, F609; and<br>42 CFR(s) 483.25 (d)(2)-Supervision, F689.<br><br>IJ existed at:<br>42 CFR(s) 483.21 (b)(1)-Comprehensive Care Plans, F656.<br><br>The facility submitted an acceptable Allegation of Compliance (AOC) on 12/3/18, in which the facility alleged all corrective actions were completed on 12/1/18, and the IJ removed on 12/2/18.<br><br>The SA validated the AOC on 12/4/18, and determined the IJ was removed, prior to exit. | F 000 | | |

| 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 _____ | C 12/04/2018 |

| 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 | Continued From page 2<br>Therefore the scope and severity for 42 CFR(s) 483.25 (d)(2)-Supervision, F689; 42 CFR(s) 483.21 (b)(1)-Comprehensive Care Plans, F656; 42 CFR(s) 483.12 (c)(1)(4)-Reporting of Alleged Violations, F609, was lowered from a level "J" to a scope and severity of a level "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>The facility held a license for 152 beds, with a census of 140. | F 000 | | |
| F 609 SS=J | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. | F 609 | | 1/16/19 |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 3<br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>CI MS#15548<br><br>Based on interview, record review, policy review, and facility investigation review, the facility failed to report the elopement and lack of supervision of Resident #4 to the State Agency (SA), when made aware, to ensure corrective actions were completed. This affected one (1) of three (3) residents reviewed for elopement risk. Resident #4, a demented resident with a past history of exit-seeking behaviors, assessed and care planned for an elopement risk, attempted to rise from the wheelchair and grab the front door exit approximately seven (7) times and actually eloped from the facility's front door, with assistance of a visitor, on 9/30/18. The Receptionist, responsible to monitor the door, to ensure residents did not exit the facility without supervision, was observed on video looking at her cell phone and was unaware of the resident's attempts and actual exit through the front door. The sidewalk in front of the building where Resident #4 was found by a visitor, was approximately 11 steps from the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled down the sidewalk, in front of the North Hall door facing the front of the building, and was approximately 34 steps from the front door. The resident was outside the facility from three (3) to five (5) | F 609 | F609<br>*On 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced. On 9/30/18 at approximately 2:55 PM, Resident #4's Responsible Party, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quiet for the remainder of the day.<br>The State Attorney General 's Office was notified on 11/29/18, at 7:23 PM by the Administrator of the incident of elopement involving Resident #4, which occurred on 9/30/18.On 11/30/18 at 8:53 AM, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br>*All residents have the potential to be affected by this practice. | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 4<br>minutes without supervision.<br><br>The facility's failure to report the elopement/lack of supervision to the State Agencies as required, to ensure corrective actions were taken, placed Resident #4 and other residents at risk for elopement, in a situation that was likely to cause serious harm, injury, impairment, or death.<br><br>This situation was determined to be and Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/30/18, when Resident #4, a demented resident, assessed and care planned as an elopement risk, exited the building from the front door while the Receptionist, responsible to monitor the front door, sat at the front desk, within vision of the front door/resident, on a cell phone. The Receptionist was neglectful of her duty to monitor the front door and report the resident's attempts to leave the facility, as well as the actual elopement.<br><br>On 11/29/18 at 3:48 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 12/3/18, in which the facility alleged all corrective actions were completed on 12/1/18, and the IJ removed on 12/2/18.<br><br>The SA validated the AOC on 12/4/18, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.12 (c)-Reporting, F609, was lowered from a "J" to a scope and severity of a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with | F 609 | *On 11/30/18 at 9:30 AM, training was initiated by a Nursing Home Administrator/Licensed Professional Counselor, who is not employed by this facility, to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement.On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. On 12/20/2018 the Staff Development Nurse conducted in-service during orientation on these trainings and will continue these trainings monthly for staff during monthly in-service trainings and during orientation for all new | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 5<br>regulatory requirements.<br><br>Findings include:<br><br>Review of the policy titled, "Policies and Procedures for Abuse Prevention, Investigation and Reporting", dated 2/15/10, revealed: The facility will report allegations of abuse, neglect or exploitation and shall be reported pursuant to the state Vulnerable Adults Act and appropriate action will be taken based on results of the investigation.<br><br>Review of the facility investigative report revealed on 9/30/18, Resident #4, per video, had attempted to rise from her wheelchair to open the front door exit seven (7) times and then was assisted out the front door. The Receptionist was observed on the cell phone, with her head down and not aware Resident #4 had exited the building. This investigation revealed another visitor was leaving and found Resident #4 on the sidewalk and came back in the facility and reported to the nursing staff that the resident was outside alone. The investigation revealed Resident #4 was outside alone less than five (5) minutes. Observation and review of the video revealed the sidewalk in front of the building where Resident #4 was found, was approximately 11 steps to the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled down the sidewalk, in front of the North Hall door facing the front of the building, and was approximately 34 steps from the front door when she was found by the daughter of another resident. Resident #4 was returned to the facility by LPN #1 without injury.<br><br>Review of the video on 11/19/18 at 9:20 AM, revealed on 9/30/18 at approximately 2:55 PM, | F 609 | employees.<br>*Training and orientation documentation will be audited monthly by the Director of Nursing (DON) and Staff Development Nurse for inclusion of reporting requirements. The results of these audits will be discussed at the monthly Quality Assurance (QA) Committee meeting by the DON. The QA Committee will make recommendations for actions to be taken as needed. | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 6<br>Resident #4 attempted to rise and exit the door seven (7) times before actually exiting the building with assistance of a visitor. The resident and the visitor was identified on the video by LPN #2.<br><br>In an interview on 11/29/18 at 3:03 PM, the Receptionist on duty on 9/30/18, revealed she was not aware that Resident #4 had exited the building until she was being brought back in by the facility staff. The Receptionist confirmed she was on the phone ordering food when Resident #4 was assisted out of the building by a visitor, and did not see her. The receptionist acknowledged Resident #4 had attempted to get out of locked doors before, confirming the risk. The receptionist confirmed that part of her duty was to monitor the front exit door.<br><br>Interview with the Administrator on 11/29/18 at 3:30 PM, revealed he wrote a statement of what occurred when Resident #4 exited the building on 9/30/18. The Administrator stated he was notified at home of the event and further stated the he did not determine Resident #4 exiting the building unsupervised as an elopement. The Administrator stated it was discussed with the Director of Operations and The Cooperate Nurse and determined not to be an elopement and not a reportable event. The Administrator also stated an emergency Quality Assurance (QA) meeting was not held because it was determined not to be an elopement. The Administrator stated, "Our determination of elopement is when they leave the premises." The Administrator confirmed he did not report the elopement/lack of supervision event to the SA.<br><br>Interview with the Director of Operations on | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 7<br>11/29/18 at 2:35 PM, confirmed during the investigation it was determined not to be an elopement since Resident #4 never left the premises and thus was not reported to the SA.<br><br>Interview with the Assistant Director of Nursing (ADON) #1 on 11/27/18 at 11:05 AM, revealed during the investigation when Resident #4 exited the building, the video was reviewed and showed a visitor assisted the resident out the front door and the resident going down the sidewalk in her wheelchair. She stated the video also revealed Receptionist #1 sitting at the front desk with her head down. ADON #1 stated she would consider this a reportable incident because no one was aware of Resident #4 being outside until notified by Visitor #1, who found the resident outside unsupervised. ADON #1 stated Resident #4 was care planned for elopement and assessed as an elopement risk.<br><br>The facility provided an Acceptable Allegation of Compliance, which included:<br><br>Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1, | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 8<br>where she was visually monitored.<br><br>Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior. Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18.<br><br>Corrective Actions;<br>1. On 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced.<br><br>2. On 9/30/18 at approximately 2:55 PM, Resident #4's Responsible Party, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1.<br><br>3. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day.<br><br>4. On 9/30/18 at approximately 4:40 PM, an investigation was initiated by the Administrator. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance assisted by a visitor.<br><br>5. On 9/30/18 at approximately 3:00 PM, the other two (2) residents who are at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. On 10/1/18, a magnetic lock and key pad was | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 9 | F 609 | | |

installed at the front entrance of the facility by an outside vendor, with installation initiated at approximately 9:00 AM, and completed by 3:00 PM.

7. Effective 10/1/18, the Receptionist quit during the investigation process.

8. On 11/29/18 at approximately 2:30 PM, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."

9. On 11/30/18 at 8:53 AM, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.

10. On 12/1/18 starting at approximately 8:00 AM, the MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3, assessed all residents for risk of elopement, including Resident #4 and the other two (2) residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified.

11. Summary of Training;
*On 10/1/18 at 8:00 AM, training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Trained on this date were nine (9) of 11 RNs, nine (9) of 23 LPNs, 16 of 52 CNAs, two (2) of 13 Therapy staff, one (1) of four

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 10<br>(4) Activities staff, three (3) of five (5) Administrative staff, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance, zero (0) of seven (7) Laundry staff, zero (0) of 14 Housekeeping staff, zero (0) of 15 Dietary staff, zero (0) of two (2) Medical Records staff, zero (0) of one (1) Central Supply staff, and one (1) of five (5) Nursing Clerical staff.<br><br>*On 11/1/1 at 7:15 AM, training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Trained of this date were four (4) of nine (9) RNs, 15 of 24 LPNs, 29 of 51 CNAs, nine (9) of 14 Therapy staff, four (4) of 14 Housekeeping staff, zero (0) of seven (7) laundry staff, three (3) of four (4) Activities staff, one (1) of three (3) Social Services, two (2) of two (2) Medical Records staff, one (1) of 16 Dietary staff, one (1) of four (4) Administrative staff, zero (0) of three (3) Maintenance staff, one (1) of one (1) Central Supply staff, and one (1) of three (3) Nursing Clerical staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 11<br>CNAs, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance staff, two (2) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, nine (9) of 16 Dietary staff, zero (0) of four (4) Activities staff, three (3) of four (4) Administration, two (2) of two (2) Medical Records staff, four (4) of four (4) Agency LPNs, seven (7) of seven (7) Agency CNAs, 14 of 14 Therapy staff, two (2) of three (3) Nursing Clerical staff, and one (1) of one (1) Central Supply staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, four (4) of four (4) Agency LPNs, and seven (7) of seven (7) Agency CNA staff.<br><br>*On 11/30/18 at 9:30 AM, training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date were 12 of 14 Administrative key personnel, three (3) of three (3) Corporate Staff, four (4) of four (4) LPNs, one (1) of one (1) RNs, and two (2) of two (2) Ancillary | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 12<br>Administrative staff.<br><br>*On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date were one (1) of nine (9) RNs, six (6) of 21 LPNs, 14 of 51 CNAs, two (2) Agency LPNs, seven (7) Agency CNAs, one (1) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, zero (0) of three (3) Maintenance staff, zero (0) of three (3) Social Services, zero (0) of two (2) Medical Records, one (1) of four (4) Administration, one (1) of three (3) Nursing Clerical, and zero (0) of one (1) Central Supply staff.<br><br>*On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Trained this date were five (5) of 26 staff members.<br><br>*No staff will be allowed to work until trained on these topics.<br><br>12. A Quality Assurance (QA) Committee meeting was conducted on 11/29/18, at 5:08 PM. Attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 13<br>Corporate RN, and Director of Long Term Care Operations. The following policies and procedures were reviewed by the committee with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. The committee reviewed the elopement incident involving Resident #4, which occurred on 9/30/18. The committee determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. The committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. The committee was informed by the Administrator that the Receptionist, who had no previous disciplinary actions taken, quit during the investigation process on 10/1/18. The committee recommended education begin immediately on the following policies and procedures: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. The QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18. Residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The State Attorney General 's Office was notified on 11/29/18, at 7:23 PM by the Administrator of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>14. The facility alleged all corrective action was completed on 12/1/18, and the IJ was removed | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 14 on 12/2/18.<br><br>Validation of the Allegation of Compliance included:<br><br>Based on observation, interviews, record review and facility investigation review, the State Agency (SA) validated that Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1 where she was visually monitored.<br><br>The SA validated through record review that Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior and that Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18, prior to the exit on 9/30/18.<br><br>Corrective Actions;<br>1. The SA validated through interview and record review that on 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1 with no injuries noted and no complaints | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 15<br>voiced.<br><br>2. The SA validated through interview with staff and record review that on 9/30/18, Resident #4's RP, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1, of the resident's elopement.<br><br>3. The SA validated through record review and interview with staff, that on 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day, without further exit-seeking behaviors.<br><br>4. The SA validated through interview and record review that on 9/30/18, an investigation was initiated by the Administrator, and he concluded that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance, assisted by a visitor.<br><br>5. The SA validated through interview and record review that on 9/30/18, the other two (2) residents who were at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. The SA validated through observation, interview and record review, that on 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor.<br><br>7. The SA validated through interview and record review that effective 10/1/18, the Receptionist quit | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 16<br>during the investigation process of Resident #4's elopement.<br><br>8. The SA validated through observation and interview that on 11/29/18, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. The SA validated through record review and interview that on 11/30/18, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to the nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br><br>10. The SA validated through interviews and record review that on 12/1/18, MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3 assessed all residents for risk of elopement, including Resident #4 and the other two residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified with these residents or their care plans for elopement risk behaviors.<br><br>11. The SA validated through interviews and record review the facility conducted the following training:<br><br>-On 10/1/18-training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Review of the sign-in sheets revealed | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 17<br>nine (9) RNs, nine (9) LPNs, 16 CNAs, two (2) Therapy staff, one (1) Activity staff, three (3) Administrative staff, two (2) Social Services staff, and one (1) Nursing Clerical staff was trained.<br><br>-On 11/1/18-training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Review of the sign-in sheets revealed four (4) RNs, 15 LPNs, 29 CNAs, nine (9) Therapy staff, four (4) Housekeeping staff, three (3) Activities staff, one (1) Social Services staff, two (2) Medical Records staff, one (1) Dietary staff, one (1) Administrative staff, one (1) Central Supply staff, and one (1) Nursing Clerical Staff were trained.<br><br>-On 11/29/18-training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Review of the sign-in sheets revealed six (6) RNs, 12 LPNs, 30 CNAs, two (2) Social Services staff, two (2) Housekeeping staff, one (1) Laundry staff, nine (9) Dietary staff, three (3) Administration, two (2) Medical Records staff, four (4) Agency LPNs, seven (7) Agency CNAs, 14 Therapy staff, two (2) Nursing Clerical, and one (1) Central Supply staff was trained. | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 18<br>-On 11/29/18-training was initiated by Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) RNs, 12 LPNs, 30 CNAs, four (4) Agency LPNs, and seven (7) Agency CNA staff, per review of the sign-in sheets.<br><br>-On 11/30/18-training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date, per review of the sign-in sheets, were 12 Administrative key personnel, three (3) Corporate staff, four (4) LPNs, one (1) RN, and two (2)Ancillary Administrative staff.<br><br>-On 11/30/18-training was initiated by RN #3, RN #4, and DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date, per sign-in sheets, was one (1) RN, six (6) LPNs, 14 CNAs, two (2) Agency LPNs, seven (7) agency CNAs, one (1) Housekeeping staff, one (1) Laundry staff, one (1) | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 19<br>Administration, one (1) Nursing clerical staff, and one (1) Central Supply staff.<br><br>-On 12/1/18-training was initiated by Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Per sign-in sheets, five (5) of the twenty six (26) staff members assigned to this duty were trained.<br><br>The SA validated through interview with staff and schedules, that no staff was allowed to work without training on these topics.<br><br>12. The SA validated through interviews, sign-in sheets and record review, that a Quality Assurance (QA) Committee meeting was conducted on 11/29/18, and the attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. Interviews revealed the committee reviewed the following policies and procedures with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. Interviews revealed the committee discussed the elopement incident involving Resident #4 which occurred on 9/30/18, and determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. Interviews revealed the committee reviewed actions taken by the facility to address resident safety related to elopement | F 609 | | |

| 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 _____ | C 12/04/2018 |

| 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 609 | Continued From page 20<br>risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. Interviews revealed the committee recommended education for policies and procedures, which included: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. Interviews also revealed the QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18, that residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The SA validated through interviews and record review that the State Attorney General's Office was notified on 11/29/18, by the Administrator, of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>The SA validated that all corrective actions were completed on 12/1/18, and the IJ was removed on 12/2/18. | F 609 | | |
| F 656 SS=J | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must | F 656 | | 1/16/19 |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 21<br>describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>CI MS#15548<br><br>Based on observation, interview, record review and policy review, the facility failed to implement the plan of care to ensure residents didn't exit the facility unsupervised and secure exits for one (1) of three (3) residents at risk for elopement, of | F 656 | F 656<br>*Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior. Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18. On 11/30/18 | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 22<br>seven (7) care plans reviewed; Resident #4. The facility also failed to develop a care plan for the actual elopement of Resident #4 on 9/30/18. Resident #4 a demented resident, care planned for the risk of elopement, with a past history of exit-seeking behaviors, eloped from the facility's front door on 9/30/18, assisted by a visitor, after attempting to exit by herself, and was found approximately 34 walked steps from the facility by another visitor. Resident #4 was assessed by the Registered Nurse with no injury. A staff person, the Receptionist responsible to monitor the door to ensure residents did not exit the facility without supervision, was observed on video looking at her cell phone and did not see the resident attempt and/or exit the building. The sidewalk in front of the building where Resident #4 was found, was approximately 11 steps to the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled her wheelchair down the sidewalk, in front of the North Hall door facing the front of the building, when she was found by the daughter of another resident. Resident #4 had a history of exit seeking behaviors and was care planned for hourly visual checks by the staff, and also care planned for secured exit doors.<br><br>The facility's failure to implement the care plan to have secured exit doors and supervision for residents with a known history of exit seeking behavior, placed this and other residents at risk for elopement in a situation that was likely to cause serious harm, injury, impairment, or death. This situation was determined to be and Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/30/18, when Resident #4 exited the building from the front door, assisted by a visitor, while the Receptionist | F 656 | at 8:53 AM, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br>*All residents have the potential to be affected by this practice, especially those at risk for elopement.<br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting Director of Nursing (DON) and Resident Care Coordinator/ Registered Nurse/Infection Control Nurse (RCC/RN/ICN) to all Registered Nurse (RN)s, License Practical Nurse (LPN)s, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement.<br>On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. The Staff Development Nurse will continue these trainings monthly for staff | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 23<br>sat at the front desk (a few feet away) on a cell phone and unaware that Resident #4 had attempted or actually left the building unsupervised. Resident #4 was found by a visitor on the sidewalk approximately 34 walked steps from the front door, who notified the nursing staff, and brought the resident back into the building.<br><br>On 11/29/18 at 3:48 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 12/3/18, in which the facility alleged all corrective actions were completed on 12/1/18, and the IJ removed on 12/2/18.<br><br>The SA validated the AOC on 12/4/18, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.21 (b)(1)-Comprehensive Care Plans, F656, was lowered from a "J" to a scope and severity of a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include:<br><br>Review of the policy for "Care Plans", reviewed by the facility January 2015, revealed: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.<br><br>Review of Resident #4's Care Plan dated 10/17/14, revealed the facility identified Resident #4 with a history of wandering and at times will exit seek, due to confusion related to Dementia | F 656 | during monthly in-service trainings and during orientation for all new employees. The MDS nurse will initiate elopement risk care plan for residents identified at risk for elopement upon admission.<br>*Care Plans of all residents identified as at risk for elopement will be reviewed for accuracy weekly in the elopement high risk meeting by the clinical team weekly times three (3) months to ensure compliance. The results of the review will be discussed at the monthly Quality Assurance (QA) Committee meeting by the DON. The QA Committee will make recommendations for actions to be taken as needed. | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 24<br>and remained at greater than ten (10) on the Elopement Risk. This Care Plan listed a goal to decrease the resident's risk factors of attempting to exit the facility without staff knowledge through the next review, effective 10/9/18. On 2/20/18, an intervention was listed to have secured exits. Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18.<br><br>Review of the cumulative Physician's Orders for the month of November 2018, revealed an order to visualize Resident #4 every hour, with an onset date of 1/3/18, related to elopement risk.<br><br>Review of the elopement risk assessment, dated 8/17/18, revealed Resident #4 scored 14. Any score greater than 10 indicated a high risk for elopement.<br><br>Review of the facility's investigation revealed Resident #4 exited the front door on 9/30/18, assisted by a visitor, while the Receptionist sat at the front desk on the phone, not aware the resident had exited the building, thus not securing the exit. The staff was notified that Resident #4 was outside alone by another visitor, Visitor #1, and the staff went outside and returned Resident #4 to the facility. Resident #4 was assessed for injuries and none were noted. Resident #4 was placed on every fifteen (15) minute checks while the RP, and the Physician was notified.<br><br>Review of the video on 11/29/18 at 9:20 AM, for 9/30/18, revealed Resident #4 attempted to rise and exit the door seven (7) times, then was assisted to exit the building by a visitor. The video revealed the Receptionist was looking down and was not aware of the resident attempting and/or | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 25<br>exiting the door. The resident and visitor was identified on the video by LPN #2.<br><br>In an interview on 11/27/18 at 4:15 PM, LPN #1 revealed Resident #4 was assessed as an elopement risk and had to be checked every one (1) hour, per the care plan. LPN #1 confirmed Resident #4's Care Plan had not been followed because she made it out the door.<br><br>In an interview on 11/3/18 at 10:50 AM, LPN #2 (Minimum Data Set Nurse), stated she was informed by the Administrator that when Resident #4 exited the building it was not considered an elopement, so the care plan was not updated or reviewed for elopement. LPN #2 stated visual checks are done every one (1) hour for Resident #4 per the care plan, and all the exit doors were secured except the one in the front, but it's now locked.<br><br>In an interview on 11/27/18 at 11:05 AM, the Assistant Director of Nursing (ADON) #1 stated Resident #4 was care planned for elopement and assessed as an elopement risk. The ADON #1 confirmed a new lock had been placed at the front door to secure the door and cannot be opened without a badge, a switch or code. She stated the Med Cart Nurse is responsible to check Resident #4 every one (1) hour and document visual observation, per the care plan. The ADON #1 confirmed Resident #4's care plan had not changed since the elopement on 9/30/18, to reflect an actual elopement.<br><br>In an interview on 11/29/18 at 3:03 PM, the Receptionist on duty 9/30/18, revealed she was not aware that Resident #4 had exited the building until she was being brought back in by | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 26 | F 656 | | |

the facility staff. She acknowledged part of her duty was to monitor the front exit door to ensure residents did not exit without supervision.

The facility provided an Acceptable Allegation of Compliance, which included:

Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1, where she was visually monitored.

Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior. Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18.

Corrective Actions;
1. On 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced.

2. On 9/30/18 at approximately 2:55 PM, Resident #4's Responsible Party, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 27<br>Nurse (RCC/RN/ICN) were notified by RN #1.<br><br>3. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day.<br><br>4. On 9/30/18 at approximately 4:40 PM, an investigation was initiated by the Administrator. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance assisted by a visitor.<br><br>5. On 9/30/18 at approximately 3:00 PM, the other two (2) residents who are at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. On 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor, with installation initiated at approximately 9:00 AM, and completed by 3:00 PM.<br><br>7. Effective 10/1/18, the Receptionist quit during the investigation process.<br><br>8. On 11/29/18 at approximately 2:30 PM, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. On 11/30/18 at 8:53 AM, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 28<br>seeking behaviors to nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br><br>10. On 12/1/18 starting at approximately 8:00 AM, the MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3, assessed all residents for risk of elopement, including Resident #4 and the other two (2) residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified.<br><br>11. Summary of Training;<br>*On 10/1/18 at 8:00 AM, training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Trained on this date were nine (9) of 11 RNs, nine (9) of 23 LPNs, 16 of 52 CNAs, two (2) of 13 Therapy staff, one (1) of four (4) Activities staff, three (3) of five (5) Administrative staff, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance, zero (0) of seven (7) Laundry staff, zero (0) of 14 Housekeeping staff, zero (0) of 15 Dietary staff, zero (0) of two (2) Medical Records staff, zero (0) of one (1) Central Supply staff, and one (1) of five (5) Nursing Clerical staff.<br><br>*On 11/1/1 at 7:15 AM, training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Trained of this date were four (4) of nine (9) RNs, 15 of 24 LPNs, 29 of 51 CNAs, nine (9) of 14 Therapy staff, four (4) of 14 Housekeeping staff, zero (0) of seven (7) laundry staff, three (3) of four (4) Activities staff, one (1) | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 29<br>of three (3) Social Services, two (2) of two (2) Medical Records staff, one (1) of 16 Dietary staff, one (1) of four (4) Administrative staff, zero (0) of three (3) Maintenance staff, one (1) of one (1) Central Supply staff, and one (1) of three (3) Nursing Clerical staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance staff, two (2) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, nine (9) of 16 Dietary staff, zero (0) of four (4) Activities staff, three (3) of four (4) Administration, two (2) of two (2) Medical Records staff, four (4) of four (4) Agency LPNs, seven (7) of seven (7) Agency CNAs, 14 of 14 Therapy staff, two (2) of three (3) Nursing Clerical staff, and one (1) of one (1) Central Supply staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 30<br>date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, four (4) of four (4) Agency LPNs, and seven (7) of seven (7) Agency CNA staff.<br><br>*On 11/30/18 at 9:30 AM, training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date were 12 of 14 Administrative key personnel, three (3) of three (3) Corporate Staff, four (4) of four (4) LPNs, one (1) of one (1) RNs, and two (2) of two (2) Ancillary Administrative staff.<br><br>*On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date were one (1) of nine (9) RNs, six (6) of 21 LPNs, 14 of 51 CNAs, two (2) Agency LPNs, seven (7) Agency CNAs, one (1) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, zero (0) of three (3) Maintenance staff, zero (0) of three (3) Social Services, zero (0) of two (2) Medical Records, one (1) of four (4) Administration, one (1) of three (3) Nursing Clerical, and zero (0) of one (1) Central Supply | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 31<br>staff.<br><br>*On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Trained this date were five (5) of 26 staff members.<br><br>*No staff will be allowed to work until trained on these topics.<br><br>12. A Quality Assurance (QA) Committee meeting was conducted on 11/29/18, at 5:08 PM. Attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. The following policies and procedures were reviewed by the committee with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. The committee reviewed the elopement incident involving Resident #4, which occurred on 9/30/18. The committee determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. The committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. The committee was informed by the Administrator that the Receptionist, who had no | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 32<br>previous disciplinary actions taken, quit during the investigation process on 10/1/18. The committee recommended education begin immediately on the following policies and procedures: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. The QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18. Residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The State Attorney General 's Office was notified on 11/29/18, at 7:23 PM by the Administrator of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>14. The facility alleged all corrective action was completed on 12/1/18, and the IJ was removed on 12/2/18.<br><br>Validation of the Allegation of Compliance included:<br><br>Based on observation, interviews, record review and facility investigation review, the State Agency (SA) validated that Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 33<br>her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1 where she was visually monitored.<br><br>The SA validated through record review that Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior and that Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18, prior to the exit on 9/30/18.<br><br>Corrective Actions;<br>1. The SA validated through interview and record review that on 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1 with no injuries noted and no complaints voiced.<br><br>2. The SA validated through interview with staff and record review that on 9/30/18, Resident #4's RP, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1, of the resident's elopement.<br><br>3. The SA validated through record review and interview with staff, that on 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day, without further exit-seeking behaviors. | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 34<br>4. The SA validated through interview and record review that on 9/30/18, an investigation was initiated by the Administrator, and he concluded that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance, assisted by a visitor.<br><br>5. The SA validated through interview and record review that on 9/30/18, the other two (2) residents who were at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. The SA validated through observation, interview and record review, that on 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor.<br><br>7. The SA validated through interview and record review that effective 10/1/18, the Receptionist quit during the investigation process of Resident #4's elopement.<br><br>8. The SA validated through observation and interview that on 11/29/18, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. The SA validated through record review and interview that on 11/30/18, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to the nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 35<br>behavior is exhibited.<br><br>10. The SA validated through interviews and record review that on 12/1/18, MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3 assessed all residents for risk of elopement, including Resident #4 and the other two residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified with these residents or their care plans for elopement risk behaviors.<br><br>11. The SA validated through interviews and record review the facility conducted the following training:<br><br>-On 10/1/18-training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Review of the sign-in sheets revealed nine (9) RNs, nine (9) LPNs, 16 CNAs, two (2) Therapy staff, one (1) Activity staff, three (3) Administrative staff, two (2) Social Services staff, and one (1) Nursing Clerical staff was trained.<br><br>-On 11/1/18-training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Review of the sign-in sheets revealed four (4) RNs, 15 LPNs, 29 CNAs, nine (9) Therapy staff, four (4) Housekeeping staff, three (3) Activities staff, one (1) Social Services staff, two (2) Medical Records staff, one (1) Dietary staff, one (1) Administrative staff, one (1) Central Supply staff, and one (1) Nursing Clerical Staff were trained. | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 36<br>-On 11/29/18-training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Review of the sign-in sheets revealed six (6) RNs, 12 LPNs, 30 CNAs, two (2) Social Services staff, two (2) Housekeeping staff, one (1) Laundry staff, nine (9) Dietary staff, three (3) Administration, two (2) Medical Records staff, four (4) Agency LPNs, seven (7) Agency CNAs, 14 Therapy staff, two (2) Nursing Clerical, and one (1) Central Supply staff was trained.<br><br>-On 11/29/18-training was initiated by Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) RNs, 12 LPNs, 30 CNAs, four (4) Agency LPNs, and seven (7) Agency CNA staff, per review of the sign-in sheets.<br><br>-On 11/30/18-training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 37<br>for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date, per review of the sign-in sheets, were 12 Administrative key personnel, three (3) Corporate staff, four (4) LPNs, one (1) RN, and two (2)Ancillary Administrative staff.<br><br>-On 11/30/18-training was initiated by RN #3, RN #4, and DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date, per sign-in sheets, was one (1) RN, six (6) LPNs, 14 CNAs, two (2) Agency LPNs, seven (7) agency CNAs, one (1) Housekeeping staff, one (1) Laundry staff, one (1) Administration, one (1) Nursing clerical staff, and one (1) Central Supply staff.<br><br>-On 12/1/18-training was initiated by Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Per sign-in sheets, five (5) of the twenty six (26) staff members assigned to this duty were trained.<br><br>The SA validated through interview with staff and schedules, that no staff was allowed to work without training on these topics. | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 38<br>12. The SA validated through interviews, sign-in sheets and record review, that a Quality Assurance (QA) Committee meeting was conducted on 11/29/18, and the attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. Interviews revealed the committee reviewed the following policies and procedures with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. Interviews revealed the committee discussed the elopement incident involving Resident #4 which occurred on 9/30/18, and determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. Interviews revealed the committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. Interviews revealed the committee recommended education for policies and procedures, which included: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. Interviews also revealed the QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18, that residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The SA validated through interviews and record review that the State Attorney General's | F 656 | | |

| 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 _____ | C 12/04/2018 |

| 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 656 | Continued From page 39<br>Office was notified on 11/29/18, by the Administrator, of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>The SA validated that all corrective actions were completed on 12/1/18, and the IJ was removed on 12/2/18. | F 656 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, interviews, facility investigation review, and policy review, the facility failed to provide adequate assessment and supervision for a confused, demented resident, with a past history of exit-seeking behaviors. Resident #4 eloped from the facility's front door on 9/30/18, assisted by a visitor, after attempting to exit by herself, and was found approximately 34 walked steps from the facility by another visitor. Resident #4 was returned by Licensed Practical Nurse (LPN) #1 with no injury. The Receptionist, responsible to monitor the door, was observed on video looking at her cell phone and did not see the resident attempt to stand seven (7) times to exit the front door, nor the exit itself, with the assistance of a visitor. There were no signs on the door to alert visitors of wandering residents. The sidewalk in | F 689 | F689<br>*On 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quiet for the remainder of the day.<br>*All residents who have been identified as at risk for elopement have potential to be affected by this practice.<br>*The Receptionist, who was responsible for monitoring the front entrance on 9/30 18, was not aware that Resident #4 exited the facility. The Receptionist quit during the investigation process. On 10/3/18, a magnetic lock and key pad was installed | 1/16/19 |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 40<br>front of the building where Resident #4 was found, was approximately 11 steps to the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled the wheelchair down the sidewalk, in front of the North Hall door facing the front of the building, when she was found by the daughter of another resident. Resident #4 had a history of exit seeking behaviors and was care planned for secured exit doors and visual checks hourly. Per video review, Resident #4 was outside without supervision approximately less than five (5) minutes before a visitor saw her, left her unattended on the sidewalk, and got assistance.<br><br>The facility's failure to implement systems for visitors to be aware of wandering residents and to supervise residents with a known history of exit seeking behavior, placed this and other residents at risk for elopement, in a situation that was likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/30/18, when Resident #4 exited the building, while the Receptionist, who's duty included monitoring the door, sat at the front desk (a few feet away) on a cell phone and was unaware that Resident #4 had left the building, assisted by a visitor, and unsupervised.<br><br>On 11/29/18 at 3:48 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 12/3/18, in which the facility alleged all corrective actions were completed on 12/1/18 and the IJ removed on 12/2/18. | F 689 | at the front entrance of the facility by an outside vendor, with installation initiated at approximately 9:00 AM, and completed by 3:00 PM.<br>On 11/29/18 at approximately 2:30 PM, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you." On 10/1/18 at 8:00 AM, training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. On 11/29/18 at 6:30 PM, training was initiated by the Acting Director of Nursing (DON) and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 41<br>The SA validated the AOC on 12/4/18, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.25 (d)(2)-Supervision, F689, was lowered from a "J" to a scope and severity of a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include:<br><br>Review of the facility's Elopement policy, dated January 2012, documented the facility will make every effort to protect the safety of all residents in the facility. Residents that are identified for risk of wandering will have an Elopement Risk Evaluation completed and will be evaluated quarterly and with a significant change. This policy noted it is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical.<br><br>Review of the facility's policy with a revision date of August 2014, and reviewed on October 2015, titled, "Wandering, Unsafe Resident", noted the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. This policy noted the staff will identify and assess residents who are at risk for harm because of unsafe wandering, including elopement.<br><br>Review of the facility's "Elopement Risk Protocol", dated July 2013, noted a resident that scored a ten (10) or greater on the risk assessment, are considered an elopement risk | F 689 | Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. The Staff Development Nurse will continue these trainings monthly for staff during monthly in-service trainings and during orientation for all new employees. An elopement drill was conducted on 12/19/2018 by the Maintenance Director and these drills will be continued monthly by the Maintenance Director.<br>*The function of the magnetic locking doors will be checked weekly for four (4) weeks then monthly. The front and south entry doors will be checked weekly for four (4) weeks and then monthly to insure the "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you." sign is posted. Training and orientation documentation will be audited monthly by the Director of Nursing (DON) and Staff Development Nurse for inclusion of reporting requirements monthly times three (3) months to ensure compliance. The results of these audits will be discussed at the monthly Quality Assurance (QA) Committee meeting by | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 42<br>The facility's policy titled, "Safety and Supervision of Residents", with a revision date of July 2017, documented: "Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.<br><br>A review of the, "Job Title: Receptionist", signed by Receptionist #1 on 2/21/18, revealed: "3. Immediately reports to Nurse any unattended Resident leaving Facility and assists as needed."<br><br>Resident #4 was admitted to the facility on 12/30/11, with diagnoses including Dementia, Gastrointestinal Esophageal Reflux Disease (GERD), and Joint Disease. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/15/18, revealed Resident #4 was unable to complete the Brief Interview for Mental Status (BIMS). Staff assessment identified Resident #4 as severely impaired and never/rarely made decisions.<br><br>Review of the facility's investigation revealed Resident #4 exited the front door, on 9/30/18, assisted by a visitor, while the Receptionist sat at the front desk on the phone and was not aware the resident had exited the building. The staff was notified that Resident #4 was outside alone by another visitor, Visitor #1, and the staff went outside and returned Resident #4 to the facility. Resident #4 was assessed for injuries and none noted. The resident was placed on every 15 minute checks while the Responsible Party (RP), and the Physician was notified.<br><br>The Resident Elopement Risk Assessment Tool for Resident #4, dated 8/17/18, had been completed with a score of 14. Any score greater than 10 indicated a high risk for elopement. | F 689 | the DON. The QA Committee will make recommendations for actions to be taken as needed. | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 43<br><br>Review of Resident #4's Care Plan dated 10/17/14, revealed the facility identified the resident had a history of wandering and at times will exit seek, due to confusion related to Dementia and remains at greater than ten (10) on the Elopement Risk. This Care Plan had a listed goal to decrease resident risk factors of exiting the facility without staff knowledge thru next review and effective 10/9/18. On 2/20/18, one of the interventions listed was to have secured exits.<br><br>Review of Resident #4's cumulative Physician's Orders for the month of November 2018, revealed an order to visualize the resident every hour for presence with an onset date of 1/3/18. (related to elopement risk).<br><br>Review of the Nurse's Notes for Resident #4, revealed a note dated 9/30/18 at 4:08 PM, by Licensed Practical Nurse (LPN) #1, that documented at approximately 2:55 PM, Resident #4 was found outside in the front of the main entrance when a visitor was leaving the facility. The Nurses Note documented the RP had been notified and Resident #4 had been assessed for injuries.<br><br>Review of the Nurses Notes for Resident #4, documented by Registered Nurse (RN) #1, noted on 9/30/18 at 2:55 PM, that she had been informed by LPN #1 that Resident #4 had been found outside of the building by a family member. This Nurses Note documented Resident #4 had no visible injuries and the Administrator, Director of Nursing (DON), Responsible Party (RP) and Medical Doctor (MD) were notified.<br><br>Observation on 11/29/18 at 4:43 PM, revealed | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 44 | F 689 | | |

there were no signs posted on the outside or inside of the exit doors to notify visitors to be aware of wandering residents and not to let anyone outside. There were approximately 40 steps from the front door to the outside front North Side door, where resident #4 was found outside.

On 11/29/18 at 9:20 AM, review of the video for 9/30/18 at approximately 2:55 PM, revealed Resident #4 sitting in a wheelchair in the lobby with Receptionist #1 sitting behind the desk and on the phone. Resident #4 was observed propelling to the front door and attempting to stand up and grab the handle of the front door. Resident #4 attempted to rise from her wheelchair seven (7) times, then a visitor walked to the front door and assisted her out the front door as he was leaving. Resident #4 was observed propelling herself down the sidewalk towards the left and out of site of the camera. Receptionist #1 continued to sit at the desk with her head down, looking at a cell phone and was not aware Resident #4 had exited the building. A longer video was provided by the facility, and Resident #4 was observed outside of the building, unsupervised for approximately three (3)-five (5) minutes when Visitor #1 found the resident alone on the sidewalk and the visitor came inside. The nurse and other staff were seen on the video rushing outside, and was seen bringing Resident #4 back into the building. At this time the Receptionist looked up and was made aware that Resident #4 had exited the building. There were three (3) cars seen on the video, passing on the street during the time that Resident #4 was outside.

In an interview on 11/29/18 at 3:30 PM, the facility

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 45<br>Administrator revealed there was an Elopement Book at each Nurses Station and at the front desk. The Administrator stated it was everyone's responsibility to assure resident's safety. The Administrator confirmed Resident #4 was found outside of the building on 9/30/18, in the afternoon with no staff present. The Administrator stated he did not determine this was an elopement. When asked how it was determined this event was not an elopement, the Administrator responded that Resident #4 was assisted out of the building by a visitor and she was found on the sidewalk and did not leave the premises, so therefore did not consider this an elopement. The Administrator continued to say, "Our definition of elopement is when they leave the premises".<br><br>In an interview, on 11/29/18 at 9:35 AM, LPN #2 confirmed the resident seen exiting the front door of the building on the video was Resident #4.<br><br>In an interview on 11/29/18 at 3:03 PM, the Receptionist that was on duty 9/30/18, Receptionist #1, revealed she was not aware that Resident #4 had exited the building (9/30/18) until she was being brought back in by the facility staff. The Receptionist stated she was on the phone ordering food when Resident #4 was assisted out of the building by a visitor. The receptionist also stated she had observed Resident #4 trying to get out a locked door before, but was not worried because she knew the door was locked and reported this to the nurse. (No time frame was provided). The receptionist stated it was the Certified Nursing Assistant (CNA)s and nurses responsibility to know where their patients are at all times. She acknowledged part of her duty was to monitor the front exit door and to report any | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 46<br>resident attempting to leave the building unsupervised.<br><br>Interview with Visitor #1 on 11/27/18 at 8:50 AM, revealed she was leaving the facility on a Sunday afternoon and found Resident #4 on the sidewalk. Visitor #1 reported that Resident #4 stated, "I don't know where I am, where am I?" Visitor #1 stated there was no staff around and staff had no idea where she was. Visitor #1 stated Resident #4 was always very confused. Visitor #1 stated she instructed Resident #4 to stay where she was and she ran inside to notify the nurse and they came and got her. When Visitor #1 returned inside, she stated Receptionist #1 stated she hoped she didn't lose her job, she was only ordering pizza or something. Visitor #1 stated the facility had a new locked placed on the front door the next day or so.<br><br>Interview with Assistant Director of Nursing (ADON) #1 on 11/27/18 at 11:05 AM, revealed during the investigation when Resident #4 exited the building, the video was reviewed and showed a visitor assisted the resident out the front door and the resident going down the sidewalk in her wheelchair. Another visitor, Visitor #1, found Resident #4 alone outside and notified the nursing staff and was returned inside. The video also revealed Receptionist #1 was sitting at the front desk with her head down. ADON #1 stated would consider this a reportable incident because no one was aware of Resident #4 being outside until notified by Visitor #1. ADON #1 stated Resident #4 was care planned for elopement and assessed as an elopement risk. The ADON #1 confirmed a new lock had been placed at the front door and the door cannot be opened without a badge, a switch, or a code. The ADON stated | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 47<br>the Med Cart Nurse is responsible to check Resident #4 every one (1) hour and document her whereabouts. She stated there had been Elopement Risk Books at all desks and at the front desk with pictures of all residents at risk for elopement.<br><br>In an interview on 11/29/18 at 2:20 PM, RN #1 revealed that she was notified that Resident #4 had exited the building and that a visitor had found her on 9/30/18. RN #1 stated she and LPN #1 conducted a body audit and the Administrator, ADON #1, and the RP was notified. She stated visual checks for Resident #4 was initiated and statements obtained. RN #1 confirmed Resident #4 had exited the building and stated, "When we came back in the receptionist was completely unaware", of Resident #4 going outside. RN #1 stated Resident #4 had been observed and was calm that day with no observed exit attempts that she knew of. RN #1 confirmed Resident #4 was on every one (1) hour visual checks because she scored high on the Elopement Risk Assessment.<br><br>In an interview with LPN #1 on 11/27/18 at 4:15 PM, she stated Visitor #1 came running up to her and notified her that Resident #4 was outside and no one was at the desk. LPN #1 stated when she went by the desk there was someone at the desk but she was bent down watching TV on her phone. LPN #1 stated Resident #4 was halfway down the sidewalk in a wheelchair and she brought her back inside. LPN #1 stated that she and RN #1 assessed Resident #4 and called the RP to notify them of the event, then everyone wrote a statement about the event. LPN #1 confirmed Resident was assessed as an elopement risk and had to be checked every one (1) hour. LPN #1 confirmed Resident #4's Care | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 48<br>Plan had not been followed, because she made it out the door unsupervised.<br><br>Interview with LPN #1 on 11/29/18 at 11:38 AM, revealed she had previously observed Resident #4 with her hands on the door, but the doors were locked and Resident #4 could not exit. LPN #1 also stated Resident #4 likes to sit by the doors. LPN #1 stated she had observed Resident #4 earlier that day for every hour checks and had seen her in activities.<br><br>Interview with LPN #2 on 11/3/18 at 10:50 AM, revealed when Resident #4 was more alert she would go to the door and push on it wanting to leave to "Get on the bus". LPN #2 stated Resident #4 did this more in the afternoons. She stated earlier this year, Resident #4 had worn a (name brand) alarm bracelet, but the bracelet was discontinued after a short while. She stated the staff monitored Resident #4 every hour for a visual check and all exit doors had been locked except the front door, but now it is locked after Resident #4 got outside. LPN #1 stated Resident #4 could have fallen out of her wheelchair or she could have gone into the traffic because of the cars going in and out of the street in front of the facility. LPN #2 stated the Receptionist failed to keep an eye on the resident; that's why she got out.<br><br>Interview with CNA #1 was attempted on 11/29/18 at 11:45 AM, but unsuccessful. CNA #1 was assigned to Resident #4 at the time of the elopement on 9/30/18, and is no longer employed with the facility.<br><br>In an interview on 11/27/18 at 12:24 PM, Contract Vender #1, a security company employee, stated | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 49<br>on 10/3/18, a lock was installed at the front door of the facility because a person "eloped". He stated the facility had it on camera, so they were called to install a lock.<br><br>The Medical Director was interviewed on 11/30/18 at 10:00 AM, and confirmed the facility notified him of the elopement for Resident #4. The Medical Director confirmed he was recently a part of the QA committee meeting where the elopement was discussed and confirmed the care plan and policies had been reviewed.<br><br>In an interview with the facility's Administrator on 11/29/18 at 11:25 AM, he stated Receptionist #1 quit during the investigation. The Administrator confirmed the Elopement Book was present at the front desk at the time of the investigation. The Administrator also confirmed there was no sign at the front door warning visitors from assisting resident out of the front door. The Administrator also confirmed it was part of the duties of the Receptionist to watch for residents leaving the building.<br><br>In an interview on 11/29/18 at 4:20 PM, LPN #3 stated she was sitting at the reception desk today and aware of the Elopement Book at the desk. She stated she has no problem seeing residents in a wheelchair in the front lobby when sitting at the desk.<br><br>The facility provided an Acceptable Allegation of Compliance, which included:<br><br>Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 50<br>on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1, where she was visually monitored.<br><br>Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior. Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18.<br><br>Corrective Actions;<br>1. On 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced.<br><br>2. On 9/30/18 at approximately 2:55 PM, Resident #4's Responsible Party, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1.<br><br>3. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day.<br><br>4. On 9/30/18 at approximately 4:40 PM, an investigation was initiated by the Administrator. The investigation revealed that the Receptionist, | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 51<br>who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance assisted by a visitor.<br><br>5. On 9/30/18 at approximately 3:00 PM, the other two (2) residents who are at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. On 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor, with installation initiated at approximately 9:00 AM, and completed by 3:00 PM.<br><br>7. Effective 10/1/18, the Receptionist quit during the investigation process.<br><br>8. On 11/29/18 at approximately 2:30 PM, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. On 11/30/18 at 8:53 AM, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br><br>10. On 12/1/18 starting at approximately 8:00 AM, the MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3, assessed all residents for risk of elopement, including Resident #4 and the other two (2) residents at risk for elopement, and | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 52<br>audited all residents' elopement risk care plans for accuracy. No concerns were identified.<br><br>11. Summary of Training;<br>*On 10/1/18 at 8:00 AM, training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Trained on this date were nine (9) of 11 RNs, nine (9) of 23 LPNs, 16 of 52 CNAs, two (2) of 13 Therapy staff, one (1) of four (4) Activities staff, three (3) of five (5) Administrative staff, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance, zero (0) of seven (7) Laundry staff, zero (0) of 14 Housekeeping staff, zero (0) of 15 Dietary staff, zero (0) of two (2) Medical Records staff, zero (0) of one (1) Central Supply staff, and one (1) of five (5) Nursing Clerical staff.<br><br>*On 11/1/1 at 7:15 AM, training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Trained of this date were four (4) of nine (9) RNs, 15 of 24 LPNs, 29 of 51 CNAs, nine (9) of 14 Therapy staff, four (4) of 14 Housekeeping staff, zero (0) of seven (7) laundry staff, three (3) of four (4) Activities staff, one (1) of three (3) Social Services, two (2) of two (2) Medical Records staff, one (1) of 16 Dietary staff, one (1) of four (4) Administrative staff, zero (0) of three (3) Maintenance staff, one (1) of one (1) Central Supply staff, and one (1) of three (3) Nursing Clerical staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 53<br>resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance staff, two (2) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, nine (9) of 16 Dietary staff, zero (0) of four (4) Activities staff, three (3) of four (4) Administration, two (2) of two (2) Medical Records staff, four (4) of four (4) Agency LPNs, seven (7) of seven (7) Agency CNAs, 14 of 14 Therapy staff, two (2) of three (3) Nursing Clerical staff, and one (1) of one (1) Central Supply staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, four (4) of four (4) Agency LPNs, and seven (7) of seven (7) Agency CNA staff.<br><br>*On 11/30/18 at 9:30 AM, training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 54<br>requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date were 12 of 14 Administrative key personnel, three (3) of three (3) Corporate Staff, four (4) of four (4) LPNs, one (1) of one (1) RNs, and two (2) of two (2) Ancillary Administrative staff.<br><br>*On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date were one (1) of nine (9) RNs, six (6) of 21 LPNs, 14 of 51 CNAs, two (2) Agency LPNs, seven (7) Agency CNAs, one (1) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, zero (0) of three (3) Maintenance staff, zero (0) of three (3) Social Services, zero (0) of two (2) Medical Records, one (1) of four (4) Administration, one (1) of three (3) Nursing Clerical, and zero (0) of one (1) Central Supply staff.<br><br>*On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 55<br>Elopement Manual. Trained this date were five (5) of 26 staff members.<br><br>*No staff will be allowed to work until trained on these topics.<br><br>12. A Quality Assurance (QA) Committee meeting was conducted on 11/29/18, at 5:08 PM. Attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. The following policies and procedures were reviewed by the committee with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. The committee reviewed the elopement incident involving Resident #4, which occurred on 9/30/18. The committee determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. The committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. The committee was informed by the Administrator that the Receptionist, who had no previous disciplinary actions taken, quit during the investigation process on 10/1/18. The committee recommended education begin immediately on the following policies and procedures: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. The QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 56<br>11/29/18. Residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The State Attorney General 's Office was notified on 11/29/18, at 7:23 PM by the Administrator of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>14. The facility alleged all corrective action was completed on 12/1/18, and the IJ was removed on 12/2/18.<br><br>Validation of the Allegation of Compliance included:<br><br>Based on observation, interviews, record review and facility investigation review, the State Agency (SA) validated that Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1 where she was visually monitored.<br><br>The SA validated through record review that Resident #4's Elopement Risk Assessment and | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 57<br>care plan was updated on 10/17/14, identifying exit seeking behavior and that Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18, prior to the exit on 9/30/18.<br><br>Corrective Actions;<br>1. The SA validated through interview and record review that on 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1 with no injuries noted and no complaints voiced.<br><br>2. The SA validated through interview with staff and record review that on 9/30/18, Resident #4's RP, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1, of the resident's elopement.<br><br>3. The SA validated through record review and interview with staff, that on 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day, without further exit-seeking behaviors.<br><br>4. The SA validated through interview and record review that on 9/30/18, an investigation was initiated by the Administrator, and he concluded that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance, assisted by a visitor.<br><br>5. The SA validated through interview and record | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 58<br>review that on 9/30/18, the other two (2) residents who were at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. The SA validated through observation, interview and record review, that on 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor.<br><br>7. The SA validated through interview and record review that effective 10/1/18, the Receptionist quit during the investigation process of Resident #4's elopement.<br><br>8. The SA validated through observation and interview that on 11/29/18, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. The SA validated through record review and interview that on 11/30/18, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to the nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br><br>10. The SA validated through interviews and record review that on 12/1/18, MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3 assessed all residents for risk of elopement, including Resident #4 and the other two residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified with these residents or their care plans | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 59<br>for elopement risk behaviors.<br><br>11. The SA validated through interviews and record review the facility conducted the following training:<br><br>-On 10/1/18-training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Review of the sign-in sheets revealed nine (9) RNs, nine (9) LPNs, 16 CNAs, two (2) Therapy staff, one (1) Activity staff, three (3) Administrative staff, two (2) Social Services staff, and one (1) Nursing Clerical staff was trained.<br><br>-On 11/1/18-training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Review of the sign-in sheets revealed four (4) RNs, 15 LPNs, 29 CNAs, nine (9) Therapy staff, four (4) Housekeeping staff, three (3) Activities staff, one (1) Social Services staff, two (2) Medical Records staff, one (1) Dietary staff, one (1) Administrative staff, one (1) Central Supply staff, and one (1) Nursing Clerical Staff were trained.<br><br>-On 11/29/18-training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 60<br>behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Review of the sign-in sheets revealed six (6) RNs, 12 LPNs, 30 CNAs, two (2) Social Services staff, two (2) Housekeeping staff, one (1) Laundry staff, nine (9) Dietary staff, three (3) Administration, two (2) Medical Records staff, four (4) Agency LPNs, seven (7) Agency CNAs, 14 Therapy staff, two (2) Nursing Clerical, and one (1) Central Supply staff was trained.<br><br>-On 11/29/18-training was initiated by Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) RNs, 12 LPNs, 30 CNAs, four (4) Agency LPNs, and seven (7) Agency CNA staff, per review of the sign-in sheets.<br><br>-On 11/30/18-training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date, per review of the sign-in sheets, were 12 Administrative key personnel, three (3) Corporate staff, four (4) LPNs, one (1) RN, and two (2)Ancillary Administrative staff. | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 61<br>-On 11/30/18-training was initiated by RN #3, RN #4, and DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date, per sign-in sheets, was one (1) RN, six (6) LPNs, 14 CNAs, two (2) Agency LPNs, seven (7) agency CNAs, one (1) Housekeeping staff, one (1) Laundry staff, one (1) Administration, one (1) Nursing clerical staff, and one (1) Central Supply staff.<br><br>-On 12/1/18-training was initiated by Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Per sign-in sheets, five (5) of the twenty six (26) staff members assigned to this duty were trained.<br><br>The SA validated through interview with staff and schedules, that no staff was allowed to work without training on these topics.<br><br>12. The SA validated through interviews, sign-in sheets and record review, that a Quality Assurance (QA) Committee meeting was conducted on 11/29/18, and the attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. Interviews revealed the committee reviewed the following policies and procedures with no | F 689 | | |

| 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 _____ | C 12/04/2018 |

| 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 689 | Continued From page 62<br>changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. Interviews revealed the committee discussed the elopement incident involving Resident #4 which occurred on 9/30/18, and determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. Interviews revealed the committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. Interviews revealed the committee recommended education for policies and procedures, which included: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. Interviews also revealed the QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18, that residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The SA validated through interviews and record review that the State Attorney General's Office was notified on 11/29/18, by the Administrator, of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>The SA validated that all corrective actions were completed on 12/1/18, and the IJ was removed on 12/2/18. | F 689 | | |

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 |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 000 | Initial Comments<br><br>CI MS #15548<br><br>The State Agency (SA) conducted a partial extended survey for Complaint Investigation (CI) MS #15548, from 11/26/18 to 12/4/18. The SA substantiated the complaint for elopement, but did not substantiate other concerns of Quality of Care/Abuse in the complaint. During the survey, it was determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M640.<br><br>The SA identified an Immediate Jeopardy (IJ) that began on 9/30/18, when the facility failed to provide adequate assessment and supervision for a confused, demented resident, with a past history of exit-seeking behaviors. Resident #4 eloped from the facility's front door on 9/30/18, assisted by a visitor, after attempting to exit by herself, and was found by another visitor. Resident #4 was assessed by RN #1 with no injury. There were no physical signs to alert visitors of wandering residents. The Receptionist, responsible to monitor the door to ensure residents did not exit the facility without supervision, was observed on video looking at her cell phone and was not aware the resident exited the building. The street was approximately 11 steps from the front door. The sidewalk in front of the building where Resident #4 was found, was approximately 11 steps to the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled down the sidewalk, in front of the North Hall door facing the front of the building, and was approximately 34 walked steps from the front door when she was found by the daughter of another resident. Resident #4 had a history of exit seeking | M 000 | | |

MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 000 | Continued From page 1<br>behaviors and was care planned for every (Q) One (1) hour visual checks by the staff and for secured exit doors. The facility Administration did not report the elopement and lack of supervision of Resident #4 to the State Agencies as required.<br><br>The failure to provide supervision and follow the care plan for Resident #4, a demented resident with a history of exit-seeking behavior, resulted in the resident's elopement from the facility and placed this resident and other demented residents in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>On 11/29/18 at 3:48 PM, the SA notified the facility's Administrator of the IJ.<br><br>IJ existed at:<br>M640-Accidents<br><br>The facility submitted an acceptable Allegation of Compliance (AOC) on 12/3/18, in which the facility alleged all corrective actions were completed on 12/1/18, and the IJ removed on 12/2/18.<br><br>The SA validated the AOC on 12/4/18, and determined the IJ was removed, prior to exit. Therefore the scope and severity for M604-Accidents, was lowered to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>The facility held a license for 152 beds, with a census of 140. | M 000 | | |

MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 2 | M 640 | | |
| M 640 | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level IV<br><br>Based on observations, record review, interviews, facility investigation review, and policy review, the facility failed to provide adequate assessment and supervision for a confused, demented resident, with a past history of exit-seeking behaviors. Resident #4 eloped from the facility's front door on 9/30/18, assisted by a visitor, after attempting to exit by herself, and was found approximately 34 walked steps from the facility by another visitor. Resident #4 was returned by Licensed Practical Nurse (LPN) #1 with no injury. The Receptionist, responsible to monitor the door, was observed on video looking at her cell phone and did not see the resident attempt to stand seven (7) times to exit the front door, nor the exit itself, with the assistance of a visitor. There were no signs on the door to alert visitors of wandering residents. The sidewalk in front of the building where Resident #4 was found, was approximately 11 steps to the street and had a curb that was approximately three (3) inches high. Resident #4 had propelled the wheelchair down the sidewalk, in front of the North Hall door facing the front of the building, when she was found by the daughter of another resident. Resident #4 had a history of exit seeking behaviors and was care planned for secured exit | M 640 | M640<br>*On 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quiet for the remainder of the day.<br>*All residents who have been identified as at risk for elopement have potential to be affected by this practice.<br>*The Receptionist, who was responsible for monitoring the front entrance on 9/30 18, was not aware that Resident #4 exited the facility. The Receptionist quit during the investigation process. On 10/3/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor, with installation initiated at approximately 9:00 AM, and completed by 3:00 PM.<br>On 11/29/18 at approximately 2:30 PM, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you." On 10/1/18 at 8:00 AM, | 1/16/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 3<br><br>doors and visual checks hourly. Per video review, Resident #4 was outside without supervision approximately less than five (5) minutes before a visitor saw her, left her unattended on the sidewalk, and got assistance.<br><br>The facility's failure to implement systems for visitors to be aware of wandering residents and to supervise residents with a known history of exit seeking behavior, placed this and other residents at risk for elopement, in a situation that was likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) that began on 9/30/18, when Resident #4 exited the building, while the Receptionist, who's duty included monitoring the door, sat at the front desk (a few feet away) on a cell phone and was unaware that Resident #4 had left the building, assisted by a visitor, and unsupervised.<br><br>On 11/29/18 at 3:48 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 12/3/18, in which the facility alleged all corrective actions were completed on 12/1/18 and the IJ removed on 12/2/18.<br><br>The SA validated the AOC on 12/4/18, and determined the IJ was removed prior to exit. Therefore the scope and severity for M640-Accidents, was lowered from a Level IV to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include: | M 640 | training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. On 11/29/18 at 6:30 PM, training was initiated by the Acting Director of Nursing (DON) and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting | |

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 |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 4<br><br>Review of the facility's Elopement policy, dated January 2012, documented the facility will make every effort to protect the safety of all residents in the facility. Residents that are identified for risk of wandering will have an Elopement Risk Evaluation completed and will be evaluated quarterly and with a significant change. This policy noted it is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical.<br><br>Review of the facility's policy with a revision date of August 2014, and reviewed on October 2015, titled, "Wandering, Unsafe Resident", noted the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. This policy noted the staff will identify and assess residents who are at risk for harm because of unsafe wandering, including elopement.<br><br>Review of the facility's "Elopement Risk Protocol", dated July 2013, noted a resident that scored a ten (10) or greater on the risk assessment, are considered an elopement risk<br><br>The facility's policy titled, "Safety and Supervision of Residents", with a revision date of July 2017, documented: "Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.<br><br>A review of the, "Job Title: Receptionist", signed by Receptionist #1 on 2/21/18, revealed: "3. Immediately reports to Nurse any unattended Resident leaving Facility and assists as needed."<br><br>Resident #4 was admitted to the facility on 12/30/11, with diagnoses including Dementia, | M 640 | requirements. The Staff Development Nurse will continue these trainings monthly for staff during monthly in-service trainings and during orientation for all new employees. An elopement drill was conducted on 12/19/2018 by the Maintenance Director and these drills will be continued monthly by the Maintenance Director.<br>*The function of the magnetic locking doors will be checked weekly for four (4) weeks then monthly. The front and south entry doors will be checked weekly for four (4) weeks and then monthly to insure the "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you." sign is posted. Training and orientation documentation will be audited monthly by the Director of Nursing (DON) and Staff Development Nurse for inclusion of reporting requirements monthly times three (3) months to ensure compliance. The results of these audits will be discussed at the monthly Quality Assurance (QA) Committee meeting by the DON. The QA Committee will make recommendations for actions to be taken as needed. | |

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 |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 5<br><br>Gastrointestinal Esophageal Reflux Disease (GERD), and Joint Disease. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/15/18, revealed Resident #4 was unable to complete the Brief Interview for Mental Status (BIMS). Staff assessment identified Resident #4 as severely impaired and never/rarely made decisions.<br><br>Review of the facility's investigation revealed Resident #4 exited the front door, on 9/30/18, assisted by a visitor, while the Receptionist sat at the front desk on the phone and was not aware the resident had exited the building. The staff was notified that Resident #4 was outside alone by another visitor, Visitor #1, and the staff went outside and returned Resident #4 to the facility. Resident #4 was assessed for injuries and none noted. The resident was placed on every 15 minute checks while the Responsible Party (RP), and the Physician was notified.<br><br>The Resident Elopement Risk Assessment Tool for Resident #4, dated 8/17/18, had been completed with a score of 14. Any score greater than 10 indicated a high risk for elopement.<br><br>Review of Resident #4's Care Plan dated 10/17/14, revealed the facility identified the resident had a history of wandering and at times will exit seek, due to confusion related to Dementia and remains at greater than ten (10) on the Elopement Risk. This Care Plan had a listed goal to decrease resident risk factors of exiting the facility without staff knowledge thru next review and effective 10/9/18. On 2/20/18, one of the interventions listed was to have secured exits.<br><br>Review of Resident #4's cumulative Physician's Orders for the month of November 2018, | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 6<br>revealed an order to visualize the resident every hour for presence with an onset date of 1/3/18. (related to elopement risk).<br><br>Review of the Nurse's Notes for Resident #4, revealed a note dated 9/30/18 at 4:08 PM, by Licensed Practical Nurse (LPN) #1, that documented at approximately 2:55 PM, Resident #4 was found outside in the front of the main entrance when a visitor was leaving the facility. The Nurses Note documented the RP had been notified and Resident #4 had been assessed for injuries.<br><br>Review of the Nurses Notes for Resident #4, documented by Registered Nurse (RN) #1, noted on 9/30/18 at 2:55 PM, that she had been informed by LPN #1 that Resident #4 had been found outside of the building by a family member. This Nurses Note documented Resident #4 had no visible injuries and the Administrator, Director of Nursing (DON), Responsible Party (RP) and Medical Doctor (MD) were notified.<br><br>Observation on 11/29/18 at 4:43 PM, revealed there were no signs posted on the outside or inside of the exit doors to notify visitors to be aware of wandering residents and not to let anyone outside. There were approximately 40 steps from the front door to the outside front North Side door, where resident #4 was found outside.<br><br>On 11/29/18 at 9:20 AM, review of the video for 9/30/18 at approximately 2:55 PM, revealed Resident #4 sitting in a wheelchair in the lobby with Receptionist #1 sitting behind the desk and on the phone. Resident #4 was observed propelling to the front door and attempting to stand up and grab the handle of the front door. | M 640 | | |

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 |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 7<br><br>Resident #4 attempted to rise from her wheelchair seven (7) times, then a visitor walked to the front door and assisted her out the front door as he was leaving. Resident #4 was observed propelling herself down the sidewalk towards the left and out of site of the camera. Receptionist #1 continued to sit at the desk with her head down, looking at a cell phone and was not aware Resident #4 had exited the building. A longer video was provided by the facility, and Resident #4 was observed outside of the building, unsupervised for approximately three (3)-five (5) minutes when Visitor #1 found the resident alone on the sidewalk and the visitor came inside. The nurse and other staff were seen on the video rushing outside, and was seen bringing Resident #4 back into the building. At this time the Receptionist looked up and was made aware that Resident #4 had exited the building. There were three (3) cars seen on the video, passing on the street during the time that Resident #4 was outside.<br><br>In an interview on 11/29/18 at 3:30 PM, the facility Administrator revealed there was an Elopement Book at each Nurses Station and at the front desk. The Administrator stated it was everyone's responsibility to assure resident's safety. The Administrator confirmed Resident #4 was found outside of the building on 9/30/18, in the afternoon with no staff present. The Administrator stated he did not determine this was an elopement. When asked how it was determined this event was not an elopement, the Administrator responded that Resident #4 was assisted out of the building by a visitor and she was found on the sidewalk and did not leave the premises, so therefore did not consider this an elopement. The Administrator continued to say, "Our definition of elopement is when they leave | M 640 | | |

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 |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 8<br>the premises".<br><br>In an interview, on 11/29/18 at 9:35 AM, LPN #2 confirmed the resident seen exiting the front door of the building on the video was Resident #4.<br><br>In an interview on 11/29/18 at 3:03 PM, the Receptionist that was on duty 9/30/18, Receptionist #1, revealed she was not aware that Resident #4 had exited the building (9/30/18) until she was being brought back in by the facility staff. The Receptionist stated she was on the phone ordering food when Resident #4 was assisted out of the building by a visitor. The receptionist also stated she had observed Resident #4 trying to get out a locked door before, but was not worried because she knew the door was locked and reported this to the nurse. (No time frame was provided). The receptionist stated it was the Certified Nursing Assistant (CNA)s and nurses responsibility to know where their patients are at all times. She acknowledged part of her duty was to monitor the front exit door and to report any resident attempting to leave the building unsupervised.<br><br>Interview with Visitor #1 on 11/27/18 at 8:50 AM, revealed she was leaving the facility on a Sunday afternoon and found Resident #4 on the sidewalk. Visitor #1 reported that Resident #4 stated, "I don't know where I am, where am I?" Visitor #1 stated there was no staff around and staff had no idea where she was. Visitor #1 stated Resident #4 was always very confused. Visitor #1 stated she instructed Resident #4 to stay where she was and she ran inside to notify the nurse and they came and got her. When Visitor #1 returned inside, she stated Receptionist #1 stated she hoped she didn't lose her job, she was only ordering pizza or something. Visitor #1 stated the | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 9<br>facility had a new locked placed on the front door the next day or so.<br><br>Interview with Assistant Director of Nursing (ADON) #1 on 11/27/18 at 11:05 AM, revealed during the investigation when Resident #4 exited the building, the video was reviewed and showed a visitor assisted the resident out the front door and the resident going down the sidewalk in her wheelchair. Another visitor, Visitor #1, found Resident #4 alone outside and notified the nursing staff and was returned inside. The video also revealed Receptionist #1 was sitting at the front desk with her head down. ADON #1 stated would consider this a reportable incident because no one was aware of Resident #4 being outside until notified by Visitor #1. ADON #1 stated Resident #4 was care planned for elopement and assessed as an elopement risk. The ADON #1 confirmed a new lock had been placed at the front door and the door cannot be opened without a badge, a switch, or a code. The ADON stated the Med Cart Nurse is responsible to check Resident #4 every one (1) hour and document her whereabouts. She stated there had been Elopement Risk Books at all desks and at the front desk with pictures of all residents at risk for elopement.<br><br>In an interview on 11/29/18 at 2:20 PM, RN #1 revealed that she was notified that Resident #4 had exited the building and that a visitor had found her on 9/30/18. RN #1 stated she and LPN #1 conducted a body audit and the Administrator, ADON #1, and the RP was notified. She stated visual checks for Resident #4 was initiated and statements obtained. RN #1 confirmed Resident #4 had exited the building and stated, "When we came back in the receptionist was completely unaware", of Resident #4 going outside. RN #1 | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 10<br>stated Resident #4 had been observed and was calm that day with no observed exit attempts that she knew of. RN #1 confirmed Resident #4 was on every one (1) hour visual checks because she scored high on the Elopement Risk Assessment.<br><br>In an interview with LPN #1 on 11/27/18 at 4:15 PM, she stated Visitor #1 came running up to her and notified her that Resident #4 was outside and no one was at the desk. LPN #1 stated when she went by the desk there was someone at the desk but she was bent down watching TV on her phone. LPN #1 stated Resident #4 was halfway down the sidewalk in a wheelchair and she brought her back inside. LPN #1 stated that she and RN #1 assessed Resident #4 and called the RP to notify them of the event, then everyone wrote a statement about the event. LPN #1 confirmed Resident was assessed as an elopement risk and had to be checked every one (1) hour. LPN #1 confirmed Resident #4's Care Plan had not been followed, because she made it out the door unsupervised.<br><br>Interview with LPN #1 on 11/29/18 at 11:38 AM, revealed she had previously observed Resident #4 with her hands on the door, but the doors were locked and Resident #4 could not exit. LPN #1 also stated Resident #4 likes to sit by the doors. LPN #1 stated she had observed Resident #4 earlier that day for every hour checks and had seen her in activities.<br><br>Interview with LPN #2 on 11/3/18 at 10:50 AM, revealed when Resident #4 was more alert she would go to the door and push on it wanting to leave to "Get on the bus". LPN #2 stated Resident #4 did this more in the afternoons. She stated earlier this year, Resident #4 had worn a (name brand) alarm bracelet, but the bracelet | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 11<br>was discontinued after a short while. She stated the staff monitored Resident #4 every hour for a visual check and all exit doors had been locked except the front door, but now it is locked after Resident #4 got outside. LPN #1 stated Resident #4 could have fallen out of her wheelchair or she could have gone into the traffic because of the cars going in and out of the street in front of the facility. LPN #2 stated the Receptionist failed to keep an eye on the resident; that's why she got out.<br><br>Interview with CNA #1 was attempted on 11/29/18 at 11:45 AM, but unsuccessful. CNA #1 was assigned to Resident #4 at the time of the elopement on 9/30/18, and is no longer employed with the facility.<br><br>In an interview on 11/27/18 at 12:24 PM, Contract Vender #1, a security company employee, stated on 10/3/18, a lock was installed at the front door of the facility because a person "eloped". He stated the facility had it on camera, so they were called to install a lock.<br><br>The Medical Director was interviewed on 11/30/18 at 10:00 AM, and confirmed the facility notified him of the elopement for Resident #4. The Medical Director confirmed he was recently a part of the QA committee meeting where the elopement was discussed and confirmed the care plan and policies had been reviewed.<br><br>In an interview with the facility's Administrator on 11/29/18 at 11:25 AM, he stated Receptionist #1 quit during the investigation. The Administrator confirmed the Elopement Book was present at the front desk at the time of the investigation. The Administrator also confirmed there was no sign at the front door warning visitors from assisting | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 12<br>resident out of the front door. The Administrator also confirmed it was part of the duties of the Receptionist to watch for residents leaving the building.<br><br>In an interview on 11/29/18 at 4:20 PM, LPN #3 stated she was sitting at the reception desk today and aware of the Elopement Book at the desk. She stated she has no problem seeing residents in a wheelchair in the front lobby when sitting at the desk.<br><br>The facility provided an Acceptable Allegation of Compliance, which included:<br><br>Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1, where she was visually monitored.<br><br>Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior. Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18.<br><br>Corrective Actions;<br>1. On 9/30/18 at approximately 2:55 PM, | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 13<br>Resident #4 was evaluated by Registered Nurse (RN) #1, with no injuries noted and no complaints voiced.<br><br>2. On 9/30/18 at approximately 2:55 PM, Resident #4's Responsible Party, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1.<br><br>3. On 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day.<br><br>4. On 9/30/18 at approximately 4:40 PM, an investigation was initiated by the Administrator. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance assisted by a visitor.<br><br>5. On 9/30/18 at approximately 3:00 PM, the other two (2) residents who are at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. On 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor, with installation initiated at approximately 9:00 AM, and completed by 3:00 PM.<br><br>7. Effective 10/1/18, the Receptionist quit during the investigation process.<br><br>8. On 11/29/18 at approximately 2:30 PM, signs were posted by the Administrator at each non-emergency entrance/exit stating | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 14<br>"ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. On 11/30/18 at 8:53 AM, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking behavior is exhibited.<br><br>10. On 12/1/18 starting at approximately 8:00 AM, the MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3, assessed all residents for risk of elopement, including Resident #4 and the other two (2) residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified.<br><br>11. Summary of Training;<br>*On 10/1/18 at 8:00 AM, training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Trained on this date were nine (9) of 11 RNs, nine (9) of 23 LPNs, 16 of 52 CNAs, two (2) of 13 Therapy staff, one (1) of four (4) Activities staff, three (3) of five (5) Administrative staff, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance, zero (0) of seven (7) Laundry staff, zero (0) of 14 Housekeeping staff, zero (0) of 15 Dietary staff, zero (0) of two (2) Medical Records staff, zero (0) of one (1) Central Supply staff, and one (1) of five (5) Nursing Clerical staff.<br><br>*On 11/1/1 at 7:15 AM, training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 15<br>exploitation, neglect, seclusion, and responsibility to report to supervisor. Trained of this date were four (4) of nine (9) RNs, 15 of 24 LPNs, 29 of 51 CNAs, nine (9) of 14 Therapy staff, four (4) of 14 Housekeeping staff, zero (0) of seven (7) laundry staff, three (3) of four (4) Activities staff, one (1) of three (3) Social Services, two (2) of two (2) Medical Records staff, one (1) of 16 Dietary staff, one (1) of four (4) Administrative staff, zero (0) of three (3) Maintenance staff, one (1) of one (1) Central Supply staff, and one (1) of three (3) Nursing Clerical staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by the Acting DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, two (2) of three (3) Social Services, zero (0) of three (3) Maintenance staff, two (2) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, nine (9) of 16 Dietary staff, zero (0) of four (4) Activities staff, three (3) of four (4) Administration, two (2) of two (2) Medical Records staff, four (4) of four (4) Agency LPNs, seven (7) of seven (7) Agency CNAs, 14 of 14 Therapy staff, two (2) of three (3) Nursing Clerical staff, and one (1) of one (1) Central Supply staff.<br><br>*On 11/29/18 at 6:30 PM, training was initiated by | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 16<br><br>the Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) of nine (9) RNs, 12 of 21 LPNs, 30 of 51 CNAs, four (4) of four (4) Agency LPNs, and seven (7) of seven (7) Agency CNA staff.<br><br>*On 11/30/18 at 9:30 AM, training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date were 12 of 14 Administrative key personnel, three (3) of three (3) Corporate Staff, four (4) of four (4) LPNs, one (1) of one (1) RNs, and two (2) of two (2) Ancillary Administrative staff.<br><br>*On 11/30/18 at 7:00 PM, training was initiated by RN #3, RN #4, and the DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date were one (1) of nine (9) RNs, six (6) of 21 LPNs, 14 of 51 CNAs, two (2) Agency LPNs, seven (7) Agency CNAs, one (1) of 15 Housekeeping staff, one (1) of seven (7) laundry staff, zero (0) of three (3) Maintenance staff, zero | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 17<br>(0) of three (3) Social Services, zero (0) of two (2) Medical Records, one (1) of four (4) Administration, one (1) of three (3) Nursing Clerical, and zero (0) of one (1) Central Supply staff.<br><br>*On 12/1/18 at 11:30 AM, training was initiated by the Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Trained this date were five (5) of 26 staff members.<br><br>*No staff will be allowed to work until trained on these topics.<br><br>12. A Quality Assurance (QA) Committee meeting was conducted on 11/29/18, at 5:08 PM. Attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. The following policies and procedures were reviewed by the committee with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. The committee reviewed the elopement incident involving Resident #4, which occurred on 9/30/18. The committee determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. The committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks | M 640 | | |

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 |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 18<br>for Resident #4 for 24 hours, and hourly checks ongoing. The committee was informed by the Administrator that the Receptionist, who had no previous disciplinary actions taken, quit during the investigation process on 10/1/18. The committee recommended education begin immediately on the following policies and procedures: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. The QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18. Residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The State Attorney General's Office was notified on 11/29/18, at 7:23 PM by the Administrator of the incident of elopement involving Resident #4, which occurred on 9/30/18.<br><br>14. The facility alleged all corrective action was completed on 12/1/18, and the IJ was removed on 12/2/18.<br><br>Validation of the Allegation of Compliance included:<br><br>Based on observation, interviews, record review and facility investigation review, the State Agency (SA) validated that Resident #4, a cognitively impaired resident, exited the front entrance of the facility with the assistance of a visitor at approximately 2:33 PM on 9/30/18. The investigation revealed that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 19<br>not aware that Resident #4 exited through the front entrance. Resident #4 was found sitting in her wheelchair, unsupervised, on the front sidewalk approximately 34 steps from the front entrance by a visitor at approximately 2:37 PM. The visitor alerted the nursing staff. Resident #4 was taken to South Nurses' Station area by Licensed Practical Nurse (LPN) #1 where she was visually monitored.<br><br>The SA validated through record review that Resident #4's Elopement Risk Assessment and care plan was updated on 10/17/14, identifying exit seeking behavior and that Resident #4 continued to be care planned for elopement risk with exit seeking behaviors on 8/9/18, prior to the exit on 9/30/18.<br><br>Corrective Actions;<br>1. The SA validated through interview and record review that on 9/30/18 at approximately 2:55 PM, Resident #4 was evaluated by Registered Nurse (RN) #1 with no injuries noted and no complaints voiced.<br><br>2. The SA validated through interview with staff and record review that on 9/30/18, Resident #4's RP, Daughter, Physician, Administrator, and Resident Care Coordinator/Registered Nurse/Infection Control Nurse (RCC/RN/ICN) were notified by RN #1, of the resident's elopement.<br><br>3. The SA validated through record review and interview with staff, that on 9/30/18 at approximately 3:45 PM, Resident #4 was placed on visual checks every 15 minutes for 24 hours and was observed to be calm and quite for the remainder of the day, without further exit-seeking behaviors. | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 20<br><br>4. The SA validated through interview and record review that on 9/30/18, an investigation was initiated by the Administrator, and he concluded that the Receptionist, who was responsible for monitoring the front entrance, was at the desk viewing her cell phone and was not aware that Resident #4 exited through the front entrance, assisted by a visitor.<br><br>5. The SA validated through interview and record review that on 9/30/18, the other two (2) residents who were at risk for elopement were visually observed in the facility by LPN #2 and LPN #3.<br><br>6. The SA validated through observation, interview and record review, that on 10/1/18, a magnetic lock and key pad was installed at the front entrance of the facility by an outside vendor.<br><br>7. The SA validated through interview and record review that effective 10/1/18, the Receptionist quit during the investigation process of Resident #4's elopement.<br><br>8. The SA validated through observation and interview that on 11/29/18, signs were posted by the Administrator at each non-emergency entrance/exit stating "ATTENTION: Please check with the Nurse at the Nurses' Station before assisting a resident to exit the facility. Thank you."<br><br>9. The SA validated through record review and interview that on 11/30/18, the Minimum Data Set (MDS) Nurse #1 added an intervention to Resident #4's care plan for reporting of exit seeking behaviors to the nurse, who will institute visual checks every 30 minutes for 72 hours, and then resume every hour checks if no exit seeking | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 21<br>behavior is exhibited.<br><br>10. The SA validated through interviews and record review that on 12/1/18, MDS Nurse #1, MDS Nurse #2, and MDS Nurse #3 assessed all residents for risk of elopement, including Resident #4 and the other two residents at risk for elopement, and audited all residents' elopement risk care plans for accuracy. No concerns were identified with these residents or their care plans for elopement risk behaviors.<br><br>11. The SA validated through interviews and record review the facility conducted the following training:<br><br>-On 10/1/18-training was initiated by the Staff Development Nurse to all facility staff entitled, "Elopement", which included resident safety related to elopement and safety of wandering residents. Review of the sign-in sheets revealed nine (9) RNs, nine (9) LPNs, 16 CNAs, two (2) Therapy staff, one (1) Activity staff, three (3) Administrative staff, two (2) Social Services staff, and one (1) Nursing Clerical staff was trained.<br><br>-On 11/1/18-training was initiated by RN #2, employed by another facility, to all facility staff entitled, "Abuse", which included abuse, exploitation, neglect, seclusion, and responsibility to report to supervisor. Review of the sign-in sheets revealed four (4) RNs, 15 LPNs, 29 CNAs, nine (9) Therapy staff, four (4) Housekeeping staff, three (3) Activities staff, one (1) Social Services staff, two (2) Medical Records staff, one (1) Dietary staff, one (1) Administrative staff, one (1) Central Supply staff, and one (1) Nursing Clerical Staff were trained.<br><br>-On 11/29/18-training was initiated by the Acting | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 22<br><br>DON and RCC/RN/ICN to all facility staff entitled, 1. "Elopement", which included resident safety related to elopement and safety of wandering residents. 2. "Safety and Supervision of Residents", which included the importance of resident supervision related to elopement risk, reporting of exit seeking behaviors to the nurse and required monitoring. When a resident is actively exit-seeking, the staff observing this behavior will maintain visual observation of the resident until the behavior can be reported to the resident's nurse. Review of the sign-in sheets revealed six (6) RNs, 12 LPNs, 30 CNAs, two (2) Social Services staff, two (2) Housekeeping staff, one (1) Laundry staff, nine (9) Dietary staff, three (3) Administration, two (2) Medical Records staff, four (4) Agency LPNs, seven (7) Agency CNAs, 14 Therapy staff, two (2) Nursing Clerical, and one (1) Central Supply staff was trained.<br><br>-On 11/29/18-training was initiated by Acting DON and RCC/RN/ICN to all RNs, LPNs, and Certified Nursing Assistants (CNA) entitled, "Using the Care Plan", which included use of the care plan to direct care provided to residents related to elopement. Trained on this date were six (6) RNs, 12 LPNs, 30 CNAs, four (4) Agency LPNs, and seven (7) Agency CNA staff, per review of the sign-in sheets.<br><br>-On 11/30/18-training was initiated by a Nursing Home Administrator/Licensed Professional Counselor who is not employed by this facility to all Administrative and Department Head staff entitled, "Abuse and Reporting and Accidents/Elopement", which included reporting requirements to Mississippi State Department of Health and the State Attorney General's Office for all alleged violations including abuse, neglect, exploitation, or mistreatment of a resident, the | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 23<br>definition of abuse and neglect, and the requirement of adequate supervision to prevent accidents including wandering and elopement. Trained this date, per review of the sign-in sheets, were 12 Administrative key personnel, three (3) Corporate staff, four (4) LPNs, one (1) RN, and two (2)Ancillary Administrative staff.<br><br>-On 11/30/18-training was initiated by RN #3, RN #4, and DON to all staff entitled, "Mississippi Vulnerable Persons Act/Abuse, Neglect, Report Requirements/Cell Phone Use", which included cell phone use policy, abuse and neglect, including neglect as it relates to lack of supervision and reporting requirements. Trained on this date, per sign-in sheets, was one (1) RN, six (6) LPNs, 14 CNAs, two (2) Agency LPNs, seven (7) agency CNAs, one (1) Housekeeping staff, one (1) Laundry staff, one (1) Administration, one (1) Nursing clerical staff, and one (1) Central Supply staff.<br><br>-On 12/1/18-training was initiated by Administrator to all staff that have Receptionist and/or Manager on Duty responsibilities entitled, "Addendum to Duties of Receptionist or Manager of the Day", which included assistance with access to the front entrance, monitoring of residents with exit seeking behaviors in this area, and use of the Elopement Manual. Per sign-in sheets, five (5) of the twenty six (26) staff members assigned to this duty were trained.<br><br>The SA validated through interview with staff and schedules, that no staff was allowed to work without training on these topics.<br><br>12. The SA validated through interviews, sign-in sheets and record review, that a Quality Assurance (QA) Committee meeting was | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 24<br>conducted on 11/29/18, and the attendees included the Medical Director, Administrator, Acting DON, RCC/RN/ICN, MDS Nurse #1, MDS Nurse #2, MDS Nurse #3, Corporate RN, and Director of Long Term Care Operations. Interviews revealed the committee reviewed the following policies and procedures with no changes made: Elopement, Using the Care Plan, Safety and Supervision of Residents, and Abuse Prevention, Investigation and Reporting. Interviews revealed the committee discussed the elopement incident involving Resident #4 which occurred on 9/30/18, and determined the system failure that allowed Resident #4 to exit the building unsupervised was the Receptionist using her cell phone. Interviews revealed the committee reviewed actions taken by the facility to address resident safety related to elopement risk including modifications to the front entry door operation and 15 minute visual checks for Resident #4 for 24 hours, and hourly checks ongoing. Interviews revealed the committee recommended education for policies and procedures, which included: Elopement - all staff, Safety and Supervision of Resident - all staff, Using the Care Plan - nursing staff, and Abuse, neglect and related reporting requirements - all staff. Interviews also revealed the QA Committee recommended a monitoring system for residents with exit seeking behaviors to be implemented on 11/29/18, that residents, who are actively exit-seeking, will be reported immediately to the nurse.<br><br>13. The SA validated through interviews and record review that the State Attorney General's Office was notified on 11/29/18, by the Administrator, of the incident of elopement involving Resident #4, which occurred on 9/30/18. | M 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18CR | A. BUILDING: _____ B. WING _____ | C 12/04/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| M 640 | Continued From page 25<br>The SA validated that all corrective actions were completed on 12/1/18, and the IJ was removed on 12/2/18. | M 640 | | |