STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 08/27/18 through 08/30/18. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F580, F600, F609, F641, F656, F690, F695 and F880. The facility was licensed for 120 beds, and had a census of 102 at the time of survey	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		10/22/18

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

Electronically Signed | 10/12/2018

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.

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, record review, and facility policy review, the facility failed to notify the family of Resident #44's transfer to the hospital from dialysis, for one (1) of four (4) residents reviewed for hospitalization transfers. Findings include: Review of the facility's policy titled, "Change in a Resident's Condition or Status", dated January 2013, revealed the facility shall notify the resident, his or her attending physician, and representative (sponsor) of changes in resident's medical/mental condition and/or status.	F 580	1. Resident #44's Resident Representative was contacted by assigned nurse after Resident #44 was sent to hospital last November 2017. The center has followed policy to notify physician and Resident Representative when a resident has a significant change since 8/29/2018. 2. All residents have the potential to be affected by the identified deficient practice. 3. Staff Development Coordinator	

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F 580	Continued From page 2 During an interview, on 08/28/18 at 10:35 AM, with Resident #44's daughter, revealed the facility failed to notify her that her mother was transferred from dialysis to the hospital in November. The daughter stated the hospital called her five (5) days later to ask permission to do a procedure on her mother. The daughter also said she was very upset because no one had informed her of mother's hospital transfer. Record review of the facility's Bed Hold Report revealed the resident was sent to the hospital on 11/08/2017, and returned on 11/16/2018. During an interview, on 08/30/18 at 9:36 AM, with the Director Of Nursing (DON), the DON confirmed the facility failed to notify the family that Resident #66 was transferred from Dialysis to the hospital. The DON confirmed there was no documentation in the Nurse's Notes, or in the chart stating Resident #44 was taken to the hospital from dialysis. A review of the Face sheet revealed the facility admitted Resident #44, on 03/23/2016, with diagnoses which included Pressure Ulcer of Sacrum, Atrial Fibrillation, Diabetes Mellitus and Chronic Kidney Disease. A review of Resident #44's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2018, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was moderately cognitively impaired.	F 580	in-serviced all nurses on notifying physician and resident representative on any change of condition on September 13 and 27, 2018 and completion date of October 19 and 20, 2018. 4. The center will monitor all residents sent to the hospital. The monitoring will be conducted by the Resident Care Coordinator (RCC) or Registar Nurse (RN) Supervisor. Monitoring started on October 5, 2018 and will be completed during clinical five times a week for four weeks during clinical. Audit findings will be reported by RCC or RN to the monthly QA committee for review and further actions will be taken as needed. The plan of correction will be integrated into the QA system.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		10/22/18

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F 600	Continued From page 3 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to protect a resident from physical abuse by Resident #7. Resident #7 was assessed for aggressive behaviors, and had no increased supervision after previous episodes of aggressive/abusive behavior toward other residents. This concern was identified for one (1) of 25 residents reviewed for abuse. Findings include: Review of the facility's policy titled, "Policies and Procedures for Abuse Prevention, Investigation and Reporting", dated 11/28/12, revealed III. Prevention: The facility will analyze the assessment, care planning, and monitoring of residents with behavior that might lead to conflict or neglect such as, Resident with history of aggressive behavior, repeatedly entering other Residents rooms, self injury behavior,	F 600	1. Resident #7 was sent to Geri-psych unit on 9/4/2018. Assigned nurse and Certified Nurses Assistant (CNA) monitored resident from 05/24/2018 to 09/04/2018 for change in behavior and redirected as needed until we were able to send resident out. 2. All residents have the potential to be affected by the identified deficient practice. 3. The Staff Developement Coordinator (SDC) in-serviced all staff on our policy and procedure of abuse on how to handle resident to resident altercation and when to increase supervision of every 15 minutes of resident unitl resident is sent out for evaluation. In-service took place on September 13 and 27, 2018 and will be completed on October 19 and 20, 2018.	

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F 600	Continued From page 4 communication disorders, and those who require heavy nursing care and or who are totally dependent on staff. The policy also stated the facility will comply with all other guidelines under "Prevention". Record review of the Incident Case Report, dated 05/24/2018 at 7:00 AM, revealed Resident #7 was sitting in the day room area watching television, when Resident #100 propelled herself into the dayroom per a wheelchair. (Name of Nurse) heard a "hit", and Resident #100 stated to Resident #7, "Do not hit me. It is not appropriate to hit a woman." Resident #7 stated, "I don't care." (Name of Second Nurse) removed Resident #100 from the situation. The report revealed there were no apparent injuries. The Charge Nurse, Director of Nursing (DON) and Administrator were notified. Resident stated per nurse, "Send me out, I do not care," Record review of Resident #7's Comprehensive Care Plan revealed the Problems/Strength, dated 01/24/18, for History (Hx) of geri psych admission related to (r/t) behaviors of being combative with staff, physical behaviors, aggression and stating that he is going to leave. Resident #7 had hit another resident. The goal stated the resident's physical behaviors, verbalization of planning to leave and resident's aggression towards others will decrease by next review period. The Interventions included: Contact resident's brother by phone when his is in distress. Refer the resident to the Psych Nurse Practitioner (NP), refer to Geri-Psych hospital as needed. Further review of the Care Plan revealed the Problems/Strengths, dated 06/12/18, for Hx of aggression toward other residents at times, hit another resident after being bumped into by the	F 600	4. Policy will be followed by monitoring a resident with aggressive behavior who is involved in a resident to resident altercation. Monitoring of the resident's aggressive behavior towards other residents will be monitored by Licensed Practical (LPN) Nurses and Certified Nurse Assistant (CNA) assigned to the aggressive resident. Audit findings will be reported by CNA or LPN to the monthly Quality Assurance (QA) Committee for review and further actions will be taken as needed. The plan of correction will be integrated into the QA system.	

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F 600	Continued From page 5 wheel chair. The Interventions included: Refer Resident #7 to Geri-Psych Dementia Unit, refer the resident to the Psych Nurse Practitioner (NP), and notify the primary provider of mood changes. There were no interventions to increase supervision of the resident to ensure he didn't abuse other residents. During an interview with the Director of Nurses (DON) and Administrator, on 08/30/18 at 2:02 PM, they confirmed the facility failed to protect the resident from abuse. The DON stated Resident #7 hit Resident #100 because she rolled over his foot with the wheelchair on accident. The DON stated it was a reaction because Resident #7 has a diagnosis of Dementia. The DON also said the resident does have a history of being combative with other residents and staff. During an interview, on 08/31/18 at 9:01 AM, with the Charge Nurse/Registered Nurse (RN) #6, revealed Resident #7 hit a staff member on 08/30/2018. RN #6 stated the resident has been more anxious and hard to redirect because he's been asking for his mother, who is in another nursing home. RN #6 said the facility is sending the resident back to Geri-Psych to adjust his medication. RN #6 stated the resident has a history of admissions to Psych units because of his past diagnosis of drug induced Psychosis. RN #6 also stated the resident developed early Dementia due to his prior history per the Psychiatrist. A review of the Face Sheet revealed Resident #7 was admitted by the facility on 06/14/17. A review of Resident #7's Quarterly Minimum Data Set (MDS), with an Assessment Reference	F 600		

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F 600	Continued From page 6 Date (ARD) of 03/05/2018, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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. §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. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and	F 609	1. Resident #7 was sent out to	10/22/18

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F 609	Continued From page 7 facility policy review, the facility failed to report an incident of abuse to the State Agency (SA) for one (1) of 25 residents reviewed for abuse, Resident #7. Findings include: Review of the facility's policy titled, "Policies and Procedures For Abuse Prevention, Investigation, and Reporting", dated 11/28/12, revealed: VII. Reporting and Response - A. Allegations of abuse, neglect, or exploitation shall be reported pursuant to the MS (Mississippi) Vulnerable Persons Act and appropriate action will be taken based on results of the investigation. C. The Administrator or designee will analyze occurrences of unexplained injuries, allegations of abuse, neglect, and/or exploitation and determine if changes are needed in (Name of Facility) policies and procedures to prevent reoccurrence. Review of the facility's policy titled, "Patient Protection and Affordable Care Act - 2010 (Elder Justice Act), dated 11/28/12, revealed: Policy - It is the policy of (Name of Facility) to comply with the Elder Justice Act (EJA) for reporting reasonable suspicion of a crime under 1150B of the Social Security Act. 6703(b)(3) of the Patient Protection and Affordable Care Act, (Elderly Justice Act) of 2010. Facility Reporting: A. Facility reporting is not required as part of this EJA act; only individuals are required to report suspicion of a crime. However, Federal, State or local laws my require facility reporting. For example: Federal regulations require facilities to report abuse, neglect, or misappropriation of Resident property to the SSA (Social Security Act).	F 609	Geri-psych for evaulation. Resident #7 behavior was monitored by assigned Certified Nurse Assistant and Licence Practical Nurse (LPN) until resident was sent out. Reporting of suspected resident to resident altercations will be reported to the appropriate agencies by the Administrator starting 8/29/2018. Resident Care Coordinators reviewed past six months for resident to resident altercation with no negative findings. 2. All residents have the potential to be affected by the identified deficient practice. 3. The Staff Developement Coordinator in-serviced all staff on reporting all resident to resident altercations and on the abuse policy. In-service took place on September 13 and 27, 2018 and will be completed on October 19 and 20, 2018. The Resident Care Coordinator (RCC) will go back six months to review all incident reports for resident to resident altercations. 4. The center will follow policy by monitoring any resident with aggressive behavior who is involved in a resident to resident altercation. The assigned Certified Nursing Assistant (CNA) and Nurse will monitor the resident's aggressive behavior towards other residents. The assigned CNA and Nurse will report all audit findings to the monthly Quality Assurance (QA) Committee for review and further actions will be taken as needed. The plan of correction will be	

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F 609	Continued From page 8 Record review of Resident #7's Incident Case Report, dated 5/24/2018 at 7:00 AM, revealed Resident #7 was sitting in the day room area watching television, when Resident #100 propelled herself into the dayroom. The nurse heard a hit, and Resident #100 stated to Resident #7 "do not hit me. It is not appropriate to hit a woman." Resident #7 stated, "I don't care." The resident's were separated. The Charge Nurse, Director of Nursing (DON) and Administrator were notified. Resident #7 stated per the nurse, "send me out, I do not care." The report revealed there were no apparent injuries. During an interview, on 08/30/18 2:02 PM, with the Director of Nurses (DON) and Administrator confirmed the facility failed to protect Resident #100 from abuse. The DON stated Resident #7 hit Resident #100 because she rolled over his foot with the wheelchair on accident. The DON stated it was a reaction because Resident #7 has a diagnosis of Dementia. The DON also said Resident #7 does have a history of being combative with other residents and staff. The Administrator confirmed the facility failed to report the abuse because she did not think it was willful. The Administrator said she felt Resident #7 hit Resident #100 out of a reaction of her running over his foot. Record review of Resident #7's Comprehensive Care Plan revealed the Problems/Strength, dated 01/24/18, for History (Hx) of geri psych admission related to (r/t) behaviors of being combative with staff, physical behaviors, aggression and stating that he is going to leave. Resident #7 had hit another resident. The goal stated the resident's physical behaviors, verbalization of planning to leave and resident's aggression towards others	F 609	integrated into the QA system.	

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F 609	Continued From page 9 will decrease by next review period. The Interventions included: Contact resident's brother by phone when his is in distress. Refer the resident to the Psych Nurse Practitioner (NP), refer to Geri-Psych hospital as needed. Further review of the Care Plan revealed the Problems/Strengths, dated 06/12/18, for Hx of aggression toward other residents at times, hit another resident after being bumped into by the wheel chair. The Interventions included: Refer Resident #7 to Geri-Psych Dementia Unit, refer the resident to the Psych Nurse Practitioner (NP), and notify the primary provider of mood changes. There were no interventions to increase supervision of the resident to ensure he didn't abuse other residents. On 08/31/18 at 9:01 AM, an interview with the Charge Nurse/Registered Nurse (RN) #6, revealed Resident #7 hit a staff member on 08/30/2018. RN #6 stated Resident #7 has been more anxious, and hard to redirect because he's been asking for his mother who is in another nursing home. RN #6 said the facility is sending Resident #7 back to Geri psych to adjust his medication. RN #7 stated Resident #7 has a history of admissions to psych units because of his past diagnosis of drug induced psychosis. RN #6 also stated Resident #7 developed early Dementia due to a prior history per a psychiatrist. A review of the Face Sheet revealed Resident #7 was admitted by the facility on 06/14/17. A review of Resident #7's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2018, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had	F 609		

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F 609	Continued From page 10 severe cognitive impairment	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code Resident #91's Minimum Data Set (MDS) for the use of a Bi-level Positive Airway Pressure (BIPAP) machine , for one (1) of 28 MDS assessments reviewed. Findings include: A review of the facility's policy titled, "Resident Assessment Instrument", with an effective date of January 2012, and revision dates of May 2015, October 2016, and March 2017, revealed: Policy Interpretation and Implementation - 3. Each discipline will be responsible for completing their assigned sections of the MDS. 4. Nursing will be responsible for completing and entering into the computer system MDS sections which included Section O. Special Treatments, Procedures and Programs. 9. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 10. Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. 14. All persons who have completed a portion of the MDS Resident Assessment Form must sign such	F 641	1. Resident #91 Minmum Data Set admission assessment was modified with correct code for the use of a Bilevel Positive Air Pressure (BIPAP) on 10/05/2018. The correction was done by MDS nurse. 2. All residents with BIPAP machine have the potential to be affected by the identified deficient practice. 3. Resident Care Coordinator or Registered Nurse (RN) completed the audit on 10/11/2018 of 100% of all residents with BIPAP machines MDS assessment for correct code. No negative findings were found. MDS Coordinators were sent to MDS training on October 9 and 10, 2018. 4. Monitoring of all orders for BIPAP on residents will be coded accurately on next scheduled MDS. Monitoring will take place during daily clinical meeting by MDS nurses. Audit findings will be reported by MDS nurses to the monthly Quality Assurance Committee for review and further actions as needed. The plan of correction will be integrated into the QA	10/22/18

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F 641	Continued From page 11 document attesting to the accuracy of such information. On 08/27/18 at 7:32 PM, an observation revealed a nebulizer, and a Bi-level Positive Airway Pressure (BIPAP) machine on Resident #91's bedside table. The nebulizer was noted to be un-bagged. Review of Resident #91's Admission MDS, with an Assessment Reference Date (ARD) of 08/08/18, revealed Section O 00100 G was checked for the use of the BIPAP machine. On 08/28/18 at 3:00 PM, an interview with Resident #91 revealed she stated, "oh yes, the nurse had to come in and put a bag on that (referring to the nebulizer mask) this morning. On 8/29/18 at 8:35 AM, an observation revealed Resident #91's BIPAP mask was laying on the resident's nightstand with no bag covering it. On 8/29/18 at 3:00 PM, an interview with Resident # 91 revealed she uses her BIPAP every night in order to be able to breathe. Resident #91 the staff assists her with applying the BIPAP each night. On 8/29/18 at 3:05 PM, an interview with the Director of Nurses (DON) revealed she does not see the most recent MDS coded to include the BIPAP. On 8/29/18 at 3:13 PM, an interview with Registered Nurse (RN) #4 revealed she uses the MDS manual as a guideline for coding the MDS, and the most recent comprehensive MDS, dated	F 641	system.	

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F 641	Continued From page 12 8/8/18, is not coded in section O 00100 G for the BIPAP. RN #4 stated, "I missed it". RN #4 also stated, "it's going to be an inaccurate assessment." Record review of Resident # 91's August 2018 Physician's Orders revealed an order, dated 08/01/18, for Ipratropium Bromide-Albuterol Sulfa 3 MG/3 ML-0.5 MG/3 ML (three milligrams per three milliliters - five tenths milligram per three milliliter) (Albuterol Sulfate/Ipratropium Bromide) Inhalation PRN (as needed) Q (every) 6 (six) hours. Further review of the Physician's Orders revealed a handwritten order, dated 08/28/18, for BIPAP 16/12 (Bilevel Positive Airway Pressure) while in swingbed at Bedford with current oxygen setting-clarification order. A review of the Face Sheet revealed Resident #91 was admitted by the facility, on 8/1/18, with a diagnosis of Obstructive Sleep Apnea. Review of the Admission MDS, with an ARD of 08/08/18, revealed Resident #91's Basic Interview for Mental Status (BIMS) score was 15, which indicated no cognitive impairment.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		10/22/18

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F 656	Continued From page 13 assessment. The comprehensive care plan must describe the following - (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 (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to develop a care plan for incontinent care with measurable goals and interventions for incontinent care for Residents #3 and #86, and for Resident #91's use of a Bi-level Positive	F 656	1. Resident #3 and #86 care plans were updated on 10/05/2018 showing incontinent care with measureable goals and interventions by Minmum Data Set (MDS) nurse. Resident #91 care plan was developed on 10/05/2018 showing	

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F 656	Continued From page 14 Airway Pressure (BIPAP) machine, and storage of Resident #91's BIPAP and nebulizer masks for three (3) of 25 care plans reviewed. Findings include: Review of the facility's policy titled, "Care Plan - Comprehensive", dated March 2017, revealed that an individualized comprehensive person-centered care plan including measurable objectives and needs will be developed for each resident. The facility policy also revealed the Interdisciplinary team will document in the Care Area Assessment (CAA) Summary sheet, evidence that the team considered the development of care planning interventions for all Care Areas Triggered (CAT) by the Minimum Data Set (MDS). The Comprehensive Care Plan is designed to identify the professional services that are responsible for each element of care. Care plans are entered into the electronic medical record and are available for staff to view as needed. Resident #3 Record review of Resident #3's Comprehensive Care Plan revealed the Problems/Strengths at risk for skin breakdown, dated 08/22/14, related to (r/t) 04/13/16 frequent bladder incontinent episodes, and occasional bowel incontinent episodes. Further review of the care plan revealed the Problems/Strengths for assist with toilet use, dated 08/22/14, due to 09/28/16 frequent bladder incontinent episodes, and occasional bowel incontinent episodes, and risk for Urinary Tract Infections (UTI), dated 08/22/14, due to repeat UTIs. Review of the care plan revealed a problem for bowel and bladder	F 656	Bilevel Positive Air Pressure (BIPAP) use and mask storage by MDS nurse. 2. All residents with incontinent care and BIPAP have the potential to be affected by the identified deficient practice. 3. Resident Care Coordinator or Registered Nurses (RN) will complete audit on 10/19/2018 of 100% of all residents with BIPAP machines and incontinent care with measurable goals and interventions on care plan. MDS nurses were in-serviced on updating care plans by Staffing Development Coordinator on 10/22/2018. 4. Monitoring of all orders for BIPAP on residents will be updated on care plan accurately as needed. Monitoring of all resident by MDS nurses with incontinent care to ensure measureable goals and interventions are in place will be completed when change of condition or new resident is admitted by Inter Disciplinary Team. Monitoring will take place during daily clinical meeting by Resident Care Coordinators (RCC). Audit findings will be reported by RCC or MDS nurses to the monthly Quality Assurance (QA) committee for review and further actions as needed. The plan of correction will be integrated into the QA system.	

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F 656	Continued From page 15 incontinence with measurable goals, objectives and interventions, was not listed on the resident's Comprehensive Care Plan as a focused problem. An observation, on 08/28/18 at 9:56 AM, revealed Certified Nursing Assistant (CNA) #2 provided Resident #3's incontinent care. Record review of Resident #3's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2018, revealed the resident was always incontinent of bladder, and frequently incontinent of bowel. Record review of Resident #3's Quarterly MDS, with an ARD of 08/17/2018, revealed the resident was always incontinent of bladder, and frequently incontinent of bowel. During an interview, on 08/29/2018 at 3:09 PM, with Registered Nurse (RN) #4/ MDS/Care Plan Coordinator, RN #4 revealed incontinence was only identified as a possible risk for a skin break down, and Resident #3's Care Plan did not include a focused problem for incontinence with providing incontinent care as an intervention. RN #4 also confirmed providing incontinent care was not listed as an intervention under the skin at risk problem.RN #4 stated the Care Area Assessment (CAA) for the Significant Change MDS completed on 02/26/2018, did identify Urinary Incontinence as a focused area. RN# 4 also stated it was marked as being carried to the care plan. RN #4 stated she uses the Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument Manual as her guide for the MDS and the care plan. RN #4 stated the care plan is reviewed by the Interdisciplinary (ID) team at	F 656		

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F 656	Continued From page 16 least quarterly, when something changes, and when the care plan needs to be updated. RN #4 stated the MDS(s) were correct as coded, and that the information coded on the MDS(s) was collected from the nursing documentation. A review of the Face Sheet revealed the facility admitted Resident #3, on 08/14/2014, with the included diagnoses Alzheimer's Disease and Lymphangtis. Review of Resident #3's Quarterly MDS, with an ARD of 08/17/18, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #86 Review of Resident #86's Comprehensive Care Plan revealed the Problems/Strengths for requires extensive assist x 1 (times one) for bathing, dressing and personal hygiene, dated 10/23/17. The interventions included provide extensive assist x 1(one) for toileting, and personal hygiene. The Problems/Strengths for risk for skin breakdown related to (r/t) extensive assist needed for bed mobility due to weakness and pain in left knee, dated 10/23/17. The Interventions included: Monitor skin for redness, and apply Desitin to redness on buttocks. bid (twice a day). On 08/30/18 10:30 AM, an observation revealed Certified Nursing Assistant (CNA) #1 provided Resident #86's bowel and bladder incontinent care. An interview, on 08/29/2018 at 2:00 PM, with Registered Nurse (RN) #4/MDS/Care Plan	F 656		

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F 656	Continued From page 17 Coordinator, revealed the Care Plan for Resident #86 did not include a problem for incontinence, or an intervention for providing incontinent care. RN # 4 stated incontinence was only identified as a possible risk for the problem at risk for skin break down, and there were no interventions to provide incontinent care. RN #4 revealed Incontinence was identified as a focused area on the CAA (Care Area Assessment) for the Significant Change MDS completed, on 08/01/2018. RN #4 stated the Incontinence was checked to be carried over to the care plan. A review of the Face Sheet revealed the facility admitted Resident #86, on 10/12/2017, with included diagnoses Bipolar Disorder, Other Chronic Pain, Generalized Weakness, Dysphasia, , and Symbolic dysfunction and Major Depressive Disorder. Review of Resident #86's Significant Change MDS, with an ARD of 08/01/18, revealed a Brief Interview of Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #86 was coded always incontinent of bladder, and always continent of bowel. Resident #91 Review of Resident #91's Comprehensive Care Plan revealed the Problems/Strengths for risk for shortness of breath or discomfort related to (r/t) sleep apnea, obesity, and allergies, dated 08/09/18. Review of the Interventions revealed none for the use of the BIPAP machine, or storage of the BIPAP and nebulizer masks. On 08/27/18 at 7:32 PM, an observation revealed a	F 656		

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F 656	Continued From page 18 a Bi-level Positive Airway Pressure (BIPAP) machine on Resident #91's bedside table. Resident #91's nebulizer mask was lying on the bedside table without a protective covering or bag. Review of Resident #91's Admission MDS, with an Assessment Reference Date (ARD) of 08/08/18, revealed Section O 00100 G was not checked for the use of the BIPAP machine. On 08/29/18 at 8:35 AM, an observation revealed Resident #91's BIPAP mask was laying on the resident's nightstand. An interview, on 08/29/18 at 3:00 PM, with Resident # 91 revealed the staff assists her with applying the BIPAP each night, and she uses her BIPAP every night in order to be able to breathe. An interview, on 08/29/18 at 4:35 PM, with Registered Nurse (RN) #4 revealed she would expect the staff to follow the care plan once it is written. On 08/29/18 at 3:05 PM, an interview with the Director of Nurses (DON) revealed she does not see the most recent MDS coded to include the BIPAP. Record review of Resident #91's August 2018 Physician's Orders revealed an order, dated 08/01/18, for Ipratropium Bromide-Albuterol Sulfa 3 MG/3 ML-0.5 MG/3 ML (three milligrams/three milliliter - five tenths milligram/three milliliters) (Albuterol Sulfate/Ipratropium Bromide) Inhalation PRN (as needed) Q (every) 6 (six) hours. Further review of the Physician's Orders revealed an order, dated	F 656		

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F 656	Continued From page 19 08/01/18, to monitor the BIPAP Machine for effectiveness. Review of the Physician's Orders revealed a handwritten order, dated 08/28/18, for BIPAP 16/12 (Bilevel Positive Airway Pressure) while in swingbed at (Name of Facility) with current oxygen setting-clarification order. A review of the Face Sheet revealed Resident #91 was admitted by the facility, on 08/1/18, with a diagnosis of Obstructive Sleep Apnea. Review of the Admission MDS, with an ARD of 08/08/18, revealed Resident #91's Basic Interview for Mental Status (BIMS) score was 15, which indicated no cognitive impairment.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		10/22/18

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F 690	Continued From page 20 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent the possibility of a Urinary Tract Infection (UTI), or cross contamination for two (2) of three (3) incontinent care observations; Residents #3 and #86. Findings include: A review of the facility's policy titled, "Perineal Care", dated September 2013, revealed the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. The policy stated to wash the perineum moving from the inside outward to and including thighs, alternating from side to side, and using downward strokes, and change gloves and wash hands any time gloves are contaminated. The policy stated to wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the	F 690	1. Resident #3 received proper perineal care performed by assigned Certified Nurses Assistance (CNA)supervisor on 8/28/2018. Resident #86 received proper Perineal Care performed by CNA supervisor on 8/30/2018. CNA #2 was re-educated on 8/28/2018 of proper perineal care which included wiping from front to back and was checked off on the skills check list for perineal care by Staff Development Coordinator. CNA #1 was re-educated on 8/30/2018 of proper perineal care which included wiping from front to back and was checked off on the skills check list for perineal care by Staff Development Coordinator. 2. All residents who receive incontinent care have the potential to be affected by the deficient practice. 3. Staff Development Coordinator initiated perineal care training on 8/28/2018 and	

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F 690	Continued From page 21 buttocks (wipes from front to back). Change gloves and wash hands any time gloves are contaminated. The policy stated the equipment to use included soap, or other authorized cleaning agent, may use incontinent wipes. Resident #3 An observation, on 08/28/18 at 9:56 AM, of Resident #3's incontinent care provided by Certified Nursing Assistant (CNA) #2, revealed CNA #2 used 14 disposable wipes, and wiped the resident's buttocks from back to front. During an interview, on 08/28/2018 at 10:25 AM, with CNA #2, she confirmed she had wiped Resident #3's buttocks area from back to front. CNA #2 also stated she realized wiping in the wrong direction could cause a Urinary Tract Infection. Review of the facility's In-Service documentation titled, "Perineal Care Skills Sheet Using Wipes", dated 05/01/2018, revealed Certified Nursing Assistant (CNA) #2 participated in, and passed the Skill Check Off for providing perineal care using wipes. During an interview, on 08/28/2018 at 10:45 AM, with Registered Nurse (RN) #5/Unit Manager, she revealed CNA #2 was a CNA provided by the (Name of Nursing Agency). RN # 5 stated, "wiping from back to front is not how the resident's buttocks area should be cleaned." RN #5 stated wiping the wrong way could cause a Urinary Tract Infection. RN #5 stated the CNAs have recently been in-serviced on Pericare. An interview, on 08/29/2018 at 9:10 AM, with the	F 690	will complete in-services on October 15 and 22, 2018 of all CNAs and nurses on proper perineal care and a skills check off of perineal care will be completed. 4. Monitoring of perineal care will be done on 10 CNAs a week for four weeks by Staff Development Coordinator (SDC). Audit findings will be reported by SDC to the monthly Quality Assurance (QA) committee for review and further actions as needed. The plan of correction will be integrated into the QA system.	

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F 690	Continued From page 22 Registered Nurse (RN) #1/Staff Development Nurse, revealed she does all the facility's in-services and skills check-off for nurses and CNAs. RN #1 stated when an agency staff member works in the facility, the agency will send any documentation of inservices and nursing education their employee has received. RN #1 also stated she does all of the employee orientations. RN #1 confirmed CNA #2 wiped incorrectly while providing incontinent care for Resident #3. RN #1 stated she had provided CNA #2 with an incontinent care in-service on 08/28/2018. Review of typed documentation on the facility's letterhead, no date, and signed by the Director of Nurses (DON), revealed: (Name of Facility) does not have a policy in place for agency personnel, although each agency staff member go through orientation with our other employees, and are expected to perform at the same skill level. We have a check off list that each person goes through to show his/her skill level. Each resident has a plan of care that all employees, including agency personnel have access to. An interview, on 08/30/2018 at 1:11 PM, with the Director of Nursing (DON), revealed he DON stated the correct way to perform incontinent care, is to wipe from front to back. The DON stated to wipe from back to front increases the risk for a Urinary Tract Infection. The DON confirmed CNA #2 was an agency CNA, and she worked at the facility as needed. The DON also stated the facility's expectations are that the agency staff follows the same skill level. During an interview, on 08/28/2018 at 10:30 AM, with CNA #3, she confirmed wiping in the wrong	F 690		

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F 690	Continued From page 23	F 690		

direction has a possibility of giving the resident an infection.

A review of the Face Sheet revealed the facility admitted Resident #3, on 08/14/2014, with the included diagnoses Alzheimer's Disease and Lymphangtis.

Review of Resident #3's Quarterly minmum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/17/18, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #3 was coded always incontinent of bladder, and frequently incontinent of bowel.

Resident #86

An observation, on 08/30/18 at 10:30 AM, revealed Certified Nursing Assistant (CNA) #1 provided Resident #86's incontinent care. CNA #1 provided privacy and appropriate hand washing and gloving. CNA #1 used disposable wipes to provide the care, and pulled three (3) wipes from the package initially to begin the peri-care. This was a sufficient amount of wipes to complete the anterior peri-care. CNA #1 failed to pull a sufficient amount of wipes out of package prior to providing Resident #86's posterior peri-care (buttocks area), which required her to re-enter the disposable wipe package seven (7) times during the posterior peri-care, while wearing stool contaminated gloves. Resident #86 was incontinent of a large amount of soft, formed brown stool. CNA #1 completed the peri-care, removed all of the contaminated disposable items, and removed her gloves. CNA #1 donned a clean pair of gloves, and rolled all of the contaminated disposables items together and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(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 690	Continued From page 24 placed the items on the resident's bedside table. CNA #1 placed a clean brief on Resident #86 wearing the same gloves she wore to handle the contaminated disposable items. An interview at this time with CNA #1 revealed she could not identify any concerns with the peri-care she had provided to Resident #86, and she did receive training for peri-care here by the facility, and they have annual check offs. On 08/30/18 at 1:11 PM, an interview with the Director of Nurses (DON), revealed staff are trained to use disposable wipes for incontinent care, and they are taught to provide a barrier, and to pull the wipes using washed, gloved hands. The DON stated they are to pull an ample amount of wipes prior to providing care from the disposable wipes package. The DON stated they should pull enough wipes from the container to provide the care, and not go back into the wipe package to prevent contamination of the wipe container, and possible spread of infection to the resident. On 08/30/18 at 1:20 PM, an interview with Registered Nurse (RN) #1/Staff Development Nurse, revealed she was responsible for the annual skills check-offs of each staff member. RN #1 stated they use repeat demonstrations on mannequins, and/or residents. RN #1 stated when the CNAs provide peri-care they should follow the protocol for infection control by hand washing, gloving and setting up a barrier. Then, a large pile of disposable wipes are placed on a barrier, an adequate amount for the procedure. RN #1 stated if a CNA goes back into a package of the disposable wipes several times with the same gloves, she said this would constitute a big infection control breech, and the whole package	F 690		

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F 690	Continued From page 25 of wipes must be thrown away, as it would be completely un-usable due to contamination on Resident # 86, and the resident would be at risk for an infection. On 08/30/18 at 1:49 PM, an interview with CNA #1 in the presence of Registered Nurse (RN) #5/Charge Nurse revealed CNA #1 described the incontinent care she provided earlier on Resident #86. While describing her care, CNA #1 stated she had contaminated the package of wipes with the stool contaminated gloves by re-entering the package multiple times. She said she could possibly cause an infection to Resident #86. Review of CNA#1's Checklist Training Records titled, "Handwashing Skills" and "Perineal Care Skills Sheet Using Wipes, dated 6/13/18 and signed by CNA #1 and the Nurse Educator, indicated CNA #1 was competent to perform the skills. A review of the Face Sheet revealed the facility admitted Resident #86, on 10/12/2017, with included diagnoses Bipolar Disorder, Other Chronic Pain, Generalized Weakness, Dysphasia, , and Symbolic dysfunction and Major Depressive Disorder. Review of Resident #86's Significant Change MDS, with an ARD of 08/01/18, revealed a Brief Interview of Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #86 was coded to be always incontinent of bladder, and always continent of bowel.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/22/18

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F 695	Continued From page 26 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store Resident #91's nebulizer mask in a manner to prevent a possible respiratory infection, for one (1) of seven (7) resident nebulizer masks observed, and Bi-level Positive Airway Pressure (BIPAP) mask in a manner to prevent a possible respiratory infection, for one (1) of two (2) BIPAP masks observed. Findings include: Review of the facility's policy titled, "Administering Medications through a Small Volume (Handheld) Nebulizer", dated June 2012, revealed the purpose of this procedure is to safely administer aerosolized particles of medication into the resident's airway. The policy stated when the nebulizer equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Review of the facility's policy titled, "CPAP/BIPAP (Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure) Support, dated March 2015, revealed the General Guidelines for Cleaning for Masks, Nasal Pillows, and Tubing stated: Clean daily by placing in warm, soapy	F 695	1. Resident #91 masks were cleaned and stored in a ziplock bag by the assigned nurse on 8/29/2018. Our medical equipment supplier brought a new masks on 8/29/2018 for Resident #91. 2. All residents with BIPAP and nebulizers have the potential to be affected by the deficient practice. 3. Our medical equipment supplier in-serviced all nurses and Certified Nurses Assistants (CNA) on proper storage and cleaning of mask on August 29 and September 20, 2018. 4.Monitoring of proper storage in ziplock bag of mask will be completed daily by Inter Disciplinary Team (IDT). Audit findings will be reported by the IDT the monthly Quality Assurance (QA) committee for review and further actions as needed. The plan of correction will be integrated into the QA system.	

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F 695	Continued From page 27 water and soaking/agitating 5 (five) minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. The policy did not address the storage of the BIPAP mask. On 08/27/18 at 7:32 PM, an observation revealed a nebulizer and BIPAP machine was on Resident #91's bedside table. The nebulizer mask was not in a bag or protective container. On 08/28/18 at 3:00 PM, an interview with Resident #91 revealed she stated, "oh yes, the nurse had to come in and put a bag on that (referring to the nebulizer mask) this morning. On 8/29/18 at 8:35 AM, an observation revealed Resident #91's BIPAP mask was laying on the resident's nightstand without any type of protective covering. Record review of Resident #91's August 2018 Physician's Orders revealed an order, dated 08/01/18, for Ipratropium Bromide-Albuterol Sulfa 3 MG/3 ML-0.5 MG/3 ML (three milligrams/three milliliter - five tenths milligram/three milliliters) (Albuterol Sulfate/Ipratropium Bromide) Inhalation PRN (as needed) Q (every) 6 (six) hours. Further review of the Physician's Orders revealed an order, dated 08/01/18, to monitor the BIPAP Machine for effectiveness. Review of the Physician's Orders revealed a handwritten order, dated 08/28/18, for BIPAP 16/12 (Bilevel Positive Airway Pressure) while in swingbed at (Name of Facility) with current oxygen setting-clarification order. On 8/29/18 at 2:24 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed, the	F 695		

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F 695	Continued From page 28	F 695		

mask should not be in the resident's drawer, and is supposed to have a bag on it. LPN #1 stated it should be in a bag to keep it sterile, or else germs and stuff may get in it. LPN #1 said that could cause Resident #91 to inhale some stuff such as germs, and get an infection.

An interview, on 8/29/18 at 2:27 PM, with Registered Nurse (RN) #1 revealed the nebulizer mask should have been in a bag. RN #1 reported that would ensure the cleanliness and infection prevention for the mask. RN #1 stated Resident #91's BIPAP mask should have been in a bag also.

On 8/29/18 at 2:30 PM, an interview with RN #3 revealed the nebulizer mask should have been bagged to prevent the possibility of an infection. RN #3 stated the BIPAP mask should have been in a bag also. RN #3 stated the staff should have checked behind the resident, and if she had taken it off, to make sure it was in a bag.

An interview, on 8/29/18 at 2:35 PM, with the Director of Nurses (DON), revealed it was the facility's policy to place the nebulizer and BIPAP masks in a bag for storage. The DON stated Resident #91's nebulizer and BIPAP masks should have been bagged for storage.

Review of the facility's document titled, "Survey Preparedness/Items To Be Corrected STAT, revealed: Nebulizer and CPAP masks and oxygen tubing Must Be Bagged. All CPAP, nebulizer masks, and oxygen tubing must have a bag over it. The document was attached to a sign in sheet titled, "(Name of Local Community College) WorkForce Development". The Class Name was Survey Preparedness - Items to Correct, dated

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F 695	Continued From page 29 04/26/18 at 2:00 PM. The Instructor was the Director of Nurses (DON). The sign in sheet contained 32 staff signatures. On 8/29/18 at 3:00 PM, an interview with Resident #91 revealed the staff assists her with applying the BIPAP each night. Resident #91 stated she uses her BIPAP every night in order to be able to breathe. A review of the Face Sheet revealed Resident #91 was admitted by the facility, on 8/1/18, with a diagnosis of Obstructive Sleep Apnea. Review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/18, revealed Resident #91's Basic Interview for Mental Status (BIMS) score was 15, which indicated no cognitive impairment.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		10/22/18

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F 880	Continued From page 30 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 31 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide incontinent care in a manner to prevent the possible spread of infection by cross contamination of wipes for one (1) of three (3) residents observed for incontinent care, for Resident # 86. Findings include: Review of the facility's policy titled, "Infection Control Guidelines for all Nursing Procedures", revised September 2012 and revised August 2015, revealed: Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions and excrements regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. On 08/30/18 at 10:30 AM, an observation revealed Certified Nursing Assistant (CNA) #1 provided Resident #86's incontinent care. CNA #1 washed her hands and applied gloves, and pulled three (3) wipes from the container to begin	F 880	1. Resident #86 received proper perineal care with proper handling of wipes performed by Certified Nursing Assistant (CNA) supervisor on 8/30/2018. CNA #1 was re-educated on 8/30/2018 of proper perineal care which included handling of wipes and was checked off on the skills check list for perineal care by Staff Development Coordinator. 2. All residents who receive incontinent care have the potential to be affected by the deficient practice. 3. Staff Development Coordinator initiated perineal care training on 8/28/2018 and will complete in-services on October 15 and 22, 2018 of all CNAs and nurses on proper perineal care and a skills check off of perineal care will be completed. 4. Monitoring of perineal care will be done on 10 CNAs a week for four weeks by Staff Development Coordinator (SDC). Audit findings will be reported by SDC to the monthly Quality Assurance (QA) committee for review and further actions as needed. The plan of correction will be	

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F 880	Continued From page 32 the incontinent care. used disposable wipes to provide the care, which was sufficient to complete the anterior incontinent care. CNA #1 had to re-enter the wipe container to remove seven (7) wipes to complete the posterior incontinent care. Resident #86 was found to be incontinent of a soft brown bowel movement, and CNA #1's gloves were contaminated with the bowel movement, therefore contaminating the wipes in the wipe container each time she pulled a new wipe out. CNA #1 completed the incontinent care, and rolled al of the disposable items up together, and placed them on the bedside table. CNA #1 changed her gloves, and placed a clean brief on Resident #86. An interview at this time with CNA #86 revealed she did not identify any concerns with her incontinent care provided to Resident #86. CNA #86 stated she did receive training at the facility, and they do annual check offs. On 08/30/18 at 1:11 PM, an interview with the Director of Nurses (DON), staff are trained to use disposable wipes to provide incontinent care. The DON said they are taught to provide a barrier, and pull the wipes with washed, gloved hands, and to pull an ample amount of wipes prior to providing care from the disposable wipes package. The DON said they are instructed to pull a pile of wipes required for the procedure, and do not go back into wipe package. The DON said If this was now followed, then it would constitute a break in infection control and contaminate the entire package of wipes requiring the package to be thrown away. An interview, on 08/30/18 at 1:20 PM, with Registered Nurse (RN) #1/Staff Development Nurse revealed she is responsible for the annual skills check-offs of each staff member. RN #1	F 880	integrated into the QA system.	

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F 880	Continued From page 33 stated the staff performs repeat demonstrations on mannequins and/or the residents. RN #1 reported the CNA should set-up for incontinent care, follow the protocols for infection control by hand washing, gloving and setting up a barrier. RN #1 said a large pile of disposable wipes should be placed on a barrier, an adequate amount for the procedure. RN #1 stated going back into a package of the disposable wipes several times with same gloves would constitute a big infection control breech, and the whole package of wipes must be thrown away, as it would be completely un-usable due to contamination on Resident #86. On 08/30/18 at 1:49 PM, an interview with CNA #1 in the presence of Registered Nurse (RN) #5/Charge Nurse, revealed CNA #1 described the incontinent care she provided for Resident #86. CNA #1 stated she had contaminated the package of wipes with stool contaminated gloves by re-entering the package multiple times. CNA #1 stated the wipes should have been thrown away due to the contamination. CNA #1 stated she could have possibly spread infection due to the package of wipes is now contaminated. A review of the Face Sheet revealed the facility admitted Resident #86, on 10/12/2017, with included diagnoses Bipolar Disorder, Other Chronic Pain, Generalized Weakness, Dysphasia, and Symbolic dysfunction and Major Depressive Disorder. Review of Resident #86's Significant Change MDS, with an ARD of 08/01/18, revealed a Brief Interview of Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Resident #86 was coded to be always incontinent of	F 880		

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F 880	Continued From page 34 bladder, and always continent of bowel.	F 880		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to provide the required 30 minute fire resistance rating for smoke barrier walls in accordance with NFPA 101 sections 8.5 and NFPA 101 19.3.7.3, 8.6.7.1(1). The deficient practice affected three (3) of nine (9) smoke compartments and 28 of 102 residents on the day of the survey. Findings Include: On August 31, 2018 at 10:45 AM, observation revealed unsealed penetrations in the following	K 372	1. Maintenance will use fire rated caulking to fill unsealed and open holes in wall on 100 hall and 300 hall. Sprinkler pipe passing through wall on 300 hall will be repaired. 2. Residents on 100 and 300 hall are potentially affected by the identified deficient practice. 3. Maintenance personnel will escort all personnel and contractors in the attic and	10/19/18

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

Electronically Signed | 10/12/2018

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
	255328	A. BUILDING **01 - BEDFORD CARE CENTER OF MARION** B. WING _____	**08/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	**6434 A DALE DR** **MARION, MS 39342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 1 smoke barrier wall of the facility : 1. Magnolia 100 Hall smoke barrier located near Room 102 had contain unsealed and open holes around the conduit passing through wall. 2. Magnolia 300 Hall's smoke barrier located near Room 302 had contain unsealed and open holes around the conduit passing through wall. 3. Magnolia 300 Hall's smoke barrier located near Room 302 also contain a main, damaged sprinkler pipe passing through wall. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 372	supervise any penetration of fire walls. If fire wall are penetrated, the walls will be sealed with fire rated caulking immediately. 4. Monitoring will be on going and findings will be reported to the monthly QA committee for review and further actions as needed. The plan of correction will be integrated into the QA system.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		10/12/18

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K 918	Continued From page 2 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations and testing the facility failed to provide a generator with transfer time of ten (10) seconds in accordance with NFPA 110 Chapter 4, Table 4.1 (b) & 4.3 Type. This deficiency affected the entire facility on day of survey. Findings Include: On August 31, 2018 at, 10:10 AM, observation and testing revealed the generator had a failed test of transfer power to the facility within the required 10 seconds. The generator transferred power to the facility in 18.32 seconds. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 918	1. Maintenance had the MS power company and Patco generator company come to the alternative power source was able to supply service within 10 seconds. On 10/12/2018, the alternative power source was able to supply service in 8.4 seconds. 2. All residents are potentially affected by the identified deficient practice. 3. Maintenance will have the inspection done annually with the MS power company and generator company to monitor that the alternative power source is capable of supplying service within 10 seconds. 4. Audit findings will be reported to the monthly QA committee for review and further actions as needed. The plan of correction will be integrated into the QA system.	

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E 000	Initial Comments Survey conducted on 8/31/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 10/12/2018

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.