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
	MS38BM	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

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M 000	Initial Comments The State Agency (SA) conducted a recertification survey from 08/27/18 through 08/30/18. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes at M020, M500, M620, and M655 The facility was licensed for 120 beds, and had a census of 102 at the time of survey	M 000		
M 020	45.1.4 Duty to Report Duty to Report. All fires, explosions, natural disasters as well as avoidable deaths or avoidable, serious, or life-threatening injuries to residents resulting from fires, explosions, and natural disasters shall be reported by telephone to the Life Safety Code Division of the licensing agency by the next working day after the occurrence. The licensing agency will provide the appropriate forms to the facility which shall be completed and returned within fifteen (15) calendar days of the occurrence. All reports shall be complete and thorough and shall record, at a minimum the causal factors, date and time of occurrence, exact location of occurrence within or without the facility, and attached thereto shall be all police, fire, or other official reports. This Statute is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to report abuse to the State Agency (SA) for one of 25 residents reviewed for abuse; Resident #7.	M 020	1. Resident #7 was sent out to 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	10/22/18

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

Electronically Signed | 10/12/18

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M 020	Continued From page 1 Resident #7 On 08/29/18 Record Review of Resident #7 Incident Report dated 5/24/2018 at 0700 AM revealed Resident #7 was sitting in the day room area watching television, when Resident #100 propelled self in 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 stated per nurse, "send me out, I do not care." 08/29/18 01:54 PM Record review of the Comprehensive care Plan revealed the residents problem on 6/12/2018 has a history of aggression toward other residents at times. Resident #7 hit another resident after being bumped into by the wheel chair. The interventions is to refer Resident #7 to geri psych dementia unit, refer the resident to the psych Nurse Practitioner and notify the primary provider of mood changes. Problems #2 on 5/24/2018 revealed Resident # 7 hit another resident, has a history of geri-psych admission related to behaviors of being combative with staff, physical behaviors, aggression and stating that he is going to leave. the goal is the resident's physical behaviors, verbalization of planning to leave and resident's aggression towards others will decrease by next review period. the resident's intervention is to contact resident's brother by phone when his is in distress. Refer the resident to the psych nurse practitioner, refer to geri-psych/alliance hospital as needed. Record Review of the facilities policy on	M 020	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 integrated into the QA system.	

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M 020	Continued From page 2 08/29/2018 titled, "Policies and Procedures For Abuse Prevention, Investigation and Reporting" revealed Bedford will report to MS Department of Health, Division of Lcensure & Certification, any valid information relating to action by a court of law indicating an employee is unsuitable towork with vulnerable persons. During an interview on 08/30/18 02:02 PM with the DON and Administrator confirmed the facility failed tor 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. 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. 08/31/18 09:01 AM Interview with the charge nurse Sarah Satcher RN revealed Resident #7 hit a staff member on 08/30/2018. The RN stated the resident has been more anxious and hard to redirect because he's been asking for his mother which is in another nursing home. The RN said the facility is sending the resident back to Geri psych to adjust his medication. The RN stated the resident has a history of admissions to psych units because of his past diagnosis of drug induced psychosis. The RN also stated the resident developed early Dementia do to prior history per psychiatrist.	M 020		
M 500	45.17.2 Residents' Rights	M 500		10/22/18

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M 500	Continued From page 3 Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;	M 500		

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M 500	Continued From page 4 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have	M 500		

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M 500	Continued From page 5 policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and	M 500		

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M 500	Continued From page 6 possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to protect a resident's right to free from abuse as evidenced by Resident #7's aggressive behaviors, and the facility had not 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	M 500	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	

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M 500	Continued From page 7 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, 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	M 500	completed on October 19 and 20, 2018. 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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M 500	Continued From page 8 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. 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 Psychiatrist. A review of the Face Sheet revealed Resident #7 was admitted by the facility on 06/14/17.	M 500		

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M 500	Continued From page 9 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 severe cognitive impairment.	M 500		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II 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	M 620	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	10/22/18

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M 620	Continued From page 10 gloves are contaminated. The policy stated to wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the 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.	M 620	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 integrated into the QA system.	

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M 620	Continued From page 11 An interview, on 08/29/2018 at 9:10 AM, with the 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,	M 620		

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(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 620	Continued From page 12 with CNA #3, she confirmed wiping in the wrong 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	M 620		

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	MS38BM	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

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M 620	Continued From page 13 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 of wipes must be thrown away, as it would be	M 620		

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M 620	Continued From page 14 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.	M 620		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These	M 655		10/22/18

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M 655	Continued From page 15 special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide special needs care 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	M 655	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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	MS38BM	A. BUILDING: _____ B. WING _____	08/29/2018

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M 655	Continued From page 16 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 mask should not be in the resident's drawer, and	M 655		

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M 655	Continued From page 17 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 04/26/18 at 2:00 PM. The Instructor was the Director of Nurses (DON). The sign in sheet	M 655		

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M 655	Continued From page 18 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.	M 655		

MSDH - Health Facilities Licensure and Certification

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	MS38BM	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**

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute 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.	M1245	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.	10/12/18

Mississippi State Department of Health

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

Electronically Signed | 10/12/18