STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255153	A. BUILDING _____ B. WING _____	09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF NEWTON	1009 SOUTH MAIN STREET NEWTON, MS 39345

(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 An annual recertiufication survey was conducted at the facility from 09/04/2018 through 09/07/2018 by the State Agency (SA). The SA determined the facility was not in compliacne with the Medicare and Medicaid requirements for participation. The SA cited the following deficiencies F567, F641, and F880. The census at the time of the survey was 100, and the facility was licensed for 120 beds.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must	F 567		10/14/18

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

Electronically Signed | 10/10/2018

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F 567	Continued From page 1 maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure Resident #63 had access to her Trust Fund account after business hours, and on the weekends. This affected one (1) of 26 sampled residents out of 84 residents with Trust Fund accounts. Finding include: On 09/05/18 at 11:00 AM, an interview with Resident #63, revealed she did not have access to her money anytime she wanted/needed it. On 09/06/18 at 4:43 PM, an interview with the Business Office Manager (BOM) revealed the residents do not have access to their money on evenings and weekends because the Business Office was closed. Review of the facility's document titled, "Trial Balance", with a print date of 09/06/18 at 5:55 PM, revealed a total of 84 residents who participated in the facility's Trust Fund accounts.	F 567	Bedford Care Center of Newton is submitting this Plan of Correction pursuant to the applicable federal and state regulations. Bedford Care Center of Newton's response to these allegations is no way an admission that the facility violated any federal or state regulations or failed to follow any applicable standard of care. *Resident #63 is a Medicaid Resident and her funds were available per regulations for a Medicaid resident. The Business Office Manager gave the resident funds each time the resident requested funds. Resident #63 was discharged from the facility on 09/14/18. *Any resident with a trust fund account has potential to be affected. *The Business Office staff and Activity staff were inserviced on 10/09/18 by the	

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F 567	Continued From page 2 Resident #63's name was included on the list. Review of Resident #63's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/18, revealed the resident's Basic Interview for Mental Status (BIMS) score was 15, which indicated no cognitive impairment.	F 567	Administrator regarding the availability of resident funds per Federal Regulations on weekends through the Activity department. Petty cash will be left in the Activity Department to be disbursed by the Activity staff to residents upon request of the resident on Saturday and Sunday. Residents were made aware of the availability of funds, per Federal Regulations, on weekends by the Administrator on 10/10/18 during a special resident council meeting. Residents who did not attend the Resident Council Meeting were notified by letter addressed to Resident or Resident Representative. New residents will be made aware by information in the Resident Handbook given on Admission by the Admission Coordinator. *The Administrator and/or Social Services will monitor the availability of the resident funds by asking Residents in Resident Council monthly X 3 months if they receive funds as requested and according to Regulations. Residents that have a trust fund account, but do not attend Resident Council meetings will be asked by Social Services during their next scheduled Care Plan meeting if they receive their money as requested in a timely manner. This monitoring will be brought to the monthly Quality Assurance (QA) meeting by Social Services to evaluate the effectiveness and changes will be made as deemed necessary by the QA Committee.	
F 641	Accuracy of Assessments	F 641		10/14/18

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F 641 SS=D	Continued From page 3 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 observation, staff interview, record review, and facility policy review, the facility failed to ensure Resident #86's Minimum Data Set (MDS) was accurately coded for the identification date of an unstageable Deep Tissue Injury (DTI) for one (1) of 22 Resident MDS assessments reviewed. Findings include: A review of the facility's policy titled, "Resident Assessment Instrument", with an effective date of January 2012 and latest revision date of March 2017, revealed: 4. Nursing will be responsible for completing, and entering into the computer system MDS sections, which included Section M Skin Conditions. 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 any portion of the MDS Resident Assessment Form must sign such document attesting to the accuracy of such information. An observation, on 09/06/18 at 2:55 PM, revealed Registered Nurse (RN) #2, assisted by RN #1, provided Resident #86's wound care to the left	F 641	* Resident #86's Minimum Data Set (MDS) Comprehensive Assessment was modified on 09/07/18 by the MDS Coordinator to reflect there was no Deep Tissure Injury on 06/04/18. * All Residents have potential to be affected. * The MDS nurse was inserviced by the Director of Nursing (DON) on 09/07/18 regarding accuracy of the MDS Assessment using the facility policy which correlates with the Resident Assessment Instrument Manual. The Resident Care Coordinator (RCC) and/or DON will monitor the accuracy of MDS Assessments that indicate a new wound weekly X 7 weeks during the weekly wound meeting to assure that no new wound is claimed after the Assessment Reference Date. The results of this monitoring will be brought to the monthly Quality Assurance (QA) meeting by the RCC to evaluate the effectiveness and changes will be made as deemed necessary by the QA Committee.	

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F 641	Continued From page 4 heel. The wound bed had a purplish colored center with pink surrounding tissue, and intact skin. Record review of Resident #86's Significant Change MDS assessment, with an Assessment Reference Date (ARD) of 06/04/18, revealed section M for Skin Condition M0300-G was coded for an unstageable Deep Tissue Injury (DTI). Review of the facility's QA (Quality Assurance) Weekly Skin Report Pressure Ulcers revealed Resident #86's DTI to the left heel was identified on 06/05/18, and the treatments were to apply the A&D Ointment every shift, and float heels every shift. On 09/06/18 at 4:50 PM, an interview with the Director of Nursing, (DON) revealed, Resident #86's left heel pressure ulcer was identified, on 06/05/18, after he was transfered to the hospital on 05/26/18 for wet lung sounds, and then admitted to Hospice on 05/28/18. Review of Resident #86's June 2018 Physician's Orders revealed an order, dated 06/06/18, to apply A&D ointment to both heels every shift. Further review of the Physician's Orders revealed an order, dated 06/07/18, to float both heels every shift. Review of Resident #86's June 2018 Medication Record revealed the staff's documentation the A&D Ointment to both heels was applied every shift starting on 06/06/18, and both heels were floated started on 06/07/18. On 09/07/18 at 1:30 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed, "I	F 641		

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F 641	Continued From page 5 realize, I shouldn't have done that" (referring to the coding of the MDS on 06/04/18). LPN #1 also stated the MDS coded on 06/04/18 for the DTI was not an accurate assessment, because Resident #86's DTI was not identified unitl 06/05/18. A review of the facility's Face Sheet for Resident #86 revealed he was admitted, by the facility on 10/27/08, with the included diagnoses of Alzheimer's Disease, Dementia, Diabetes Mellitus Type II, and Congestive Heart Disease. Review of Resident #86's Significant Change MDS, with an ARD of 06/04/18, revealed the resident's cognitive skills for daily decision making was coded 3, which indicated severe impairment, never/rarely made decisions. Further review of the MDS revealed Resident #86 required extensive or total staff assistance, with one to two persons with his Activities of Daily Living (ADLs).	F 641		
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:	F 880		10/14/18

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F 880	Continued From page 6 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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.	F 880		

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F 880	Continued From page 7 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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, and facility policy review, the facility failed to pass ice in a manner to prevent cross contamination, for one of four (1 of 4) days of survey observations. Findings include: A review of the facility's policy titled, "Infection Control Guidelines for All Nursing Procedures", with a revised date of September 2012, and review date of 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 excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. On 09/05/18 at 2:40 PM, an observation revealed Certified Nursing Assistant (CNA) #1 placed the ice scooper into the cooler of ice, instead of the ice scooper holder. On 09/05/18 at 2:45 PM, an interview with CNA	F 880	* The ice scoop was removed from the ice chest by the Certified Nursing Assistant #1 on 09/05/18. * All residents receiving ice have the potential to be affected. * Nursing,Housekeeping, Dietary and Laundry staff were inserviced by the Staff Development Nurse on 09/07/18-09/22/18 regarding proper handling and storage of the ice scoop, keeping ice scoop in a covered container when not in use according to the facility policy. * The Resident Care Coordinators(RCC), Nurse Supervisor and/or Director Of Nursing will monitor daily X 4 weeks during ice pass time each shift to assure the scoop is stored properly. The results of this monitoring will be brought to the monthly Quality Assurance meeting by the Resident Care Coordinator to evaluate the effectiveness and changes will be made as deemed necessary by the QA	

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F 880	Continued From page 8 #1 revealed, she placed the ice scooper into the ice chest with the ice in it. CNA #1 stated that could cause bacteria to get in it (referring to the ice). On 09/07/18 at 1:05 PM, an interview with Registered Nurse (RN) #1 revealed, she stated it is a problem to put the ice scooper into the ice chest, and not the holder. RN #1 stated it was contaminating the ice in the chest. On 09/07/18 at 1:10 PM, an interview with RN #2 revealed, "That's cross contamination and an infection control issue." RN #2 stated she had done trainings in the past on infection control. Review of the facility's Training Sign-In Sheets, dated 12/14/17, 12/15/18, 12/19/17, 12/20/17, 12/21/17, and 12/27/17, which included Courses for Infection Control and Standard Precautions, revealed CNA #1's signature was not identified on the sign in sheets. On 09/07/18 at 1:20 PM, an interview with the Director of Nursing (DON), revealed that was a problem with the CNA putting the ice scooper back into the ice chest instead of the holder, and that is an infection control issue.	F 880	Committee.	

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	255153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 10/05/2018

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E 000	Initial Comments Survey conducted on 9/7/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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