STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 2/15/22 through 2/18/22. 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 F-623, F-645, F-690 and F880. The facility held a license for 80 beds, with a census of 66.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		4/8/22

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

Electronically Signed | 03/16/2022

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F 623	Continued From page 1	F 623		

be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 2 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to provide a written notice of transfer to the Responsible Representative (RR) for four (4) of four (4) residents reviewed. Resident #23, Resident #63, Resident #65 and Resident #67. Findings Include: Record review of the facility's policy, "Transfer or	F 623	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance.	

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F 623	Continued From page 3 Discharge, Emergency" with a Revised Date of September 2012 and a Reviewed Date of 1/2022 revealed "Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident. 1. ...e. Notify the representative (sponsor) or other family member as appropriate in writing ..." Record review of the "Re: Written Notice Requirements" form revealed " ...our regulations require this facility to send a Written Notice to Resident Representatives each time a resident is transferred to the hospital or goes out on therapeutic leave ..." Resident #23 On 02/15/22 at 2:11 PM, during a phone interview with Resident #23's RR, she explained the facility called and informed her of her mother being transferred to the hospital, but she did not receive a notification in writing of the transfer. A record review of the "Admission Record" for Resident #23 revealed the facility admitted Resident #23 on 2/14/2020 with diagnoses including but not limited to: Alzheimer's Disease with late onset, Dementia, and Essential High Blood Pressure. A record review of Resident #23's "Order Audit Report" revealed a physician order with an order date of 02/08/22 to "send to (Name of Local Hospital) emergency room for evaluation of hypotension". A record review of "Resident Notification of Transfer/Leave Bed Hold" revealed the facility completed the portion of the form of Resident	F 623	On 03/08/2022, the Quality Assurance Committee (QAC) conducted record reviews and staff interviews which concluded that for Resident #23, Resident #63, Resident #65 and Resident #67,facility policy titled "Transfer or Discharge, Emergency" (policy)was not followed by the Social Services Director (SSD). On 2/17/2022, Resident Representative Written Notice - Bedhold (form) was completed for resident #23, #63, #65 and #67 and mailed to the Resident Representative on file by the SSD. The QAC review confirmed that the policy is in current regulatory compliance and the form with a revision date of 6/2019 is in current regulatory compliance. The QAC concluded that this deficiency was related to internal process failure at the facility. All residents have the potential to be affected by the deficient practice. On 02/17/2022 the SSD was made aware by the Administrator of the facility that the SSD or BOM is responsible for providing a written notice of transfer to the Responsible Representative (RR). SSD reviewed the Code of Federal Regulations: 483.15(c)(3)-(6)(8), current facility policy and form. SSD verbalized understanding of responsibility in providing written notice of transfer to the resident's RR, the current policy and form to be used. 03/08/2022 facility QAC adopted a new process to ensure written communication	

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F 623	Continued From page 4 #23's name, date of transfer, and type of leave as transfer to hospital, but it did not indicate the reason for the transfer. A record review of nurse Progress Notes with an effective date of 2/08/22 for Resident #23 revealed, "RN was notified that (Name of Nurse Practitioner) was sending Elder to ER (Emergency Room) ..." A record review of Resident #23's Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/22 revealed she was discharged to an Acute Hospital on 2/8/22. Resident #63 Record review of the "Admission Record" revealed Resident #63 was admitted to the facility on 4/29/21 with diagnoses including Sepsis and Parkinson's Disease. Record review of the nurse Progress Notes with an effective date of 1/25/22 revealed, " ...On 1/21/22 staff reported ...He was sent to (Name of Local Hospital) ER for evaluation ...". Record review of Resident #63's MDS with an ARD of 1/21/22 revealed Resident #63 was discharged to an acute hospital on 1/21/22. Record review of the medical chart revealed there was no written notification of transfer for Resident #63. Resident #65 Record review of the "Admission Record" revealed Resident #65 was admitted to the facility	F 623	of resident transfer is achieved. Upon a resident transfer the SSD will complete the form no later than the next business day. The completed form will be presented to the Business Office Manager (BOM) or Administrator for review. The BOM or Administrator will document the date completed, resident name and initial the "Transfer Notification Log" (log). A copy of the completed form and the addressed envelope will be made and filed for reference. The envelope containing the form will be placed in the outgoing mail for pick-up by the United States Postal Service. Weekly, beginning 3/8/2022, the facility Administrator or BOM will review the facility transfers and cross reference the log to ensure compliance is achieved. Any variances will be corrected immediately by the SSD, BOM or Administrator. Log variances will be reported to the QAC initially on 4/4/2022 and quarterly thereafter for 2 quarters beginning 05/04/2022 for review by the Medical Director and Steering Committee to ensure sustained compliance.	

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F 623	Continued From page 5	F 623		

admitted on 12/14/2021 with diagnoses including Congestive Heart Failure, Type II Diabetes Mellitus, and Chronic Kidney Disease.

Record review of the "Physician Discharge Summary" with a discharge date of 1/11/22 revealed " ...Elder sent to (Name of Local Hospital) ER for evaluation ...".

Record review of Progress Notes with an effective date of 1/11/21 revealed, " ...New order to send patient to (Name of Local Hospital) ER for evaluation ...".

Record review of the MDS with an ARD of 1/11/22 revealed Resident #65 was discharged to an acute hospital on 1/11/22.

Record review of the medical chart revealed there was no written notification of transfer for Resident #65.

Resident #67

Record review of the "Admission Record" revealed the facility originally admitted Resident #67 on 10/7/20 and readmitted her on 2/15/22. Resident #67 has diagnoses including Epilepsy, Vascular Dementia and Urinary Tract Infection.

Record review of Resident #67's MDS with an ARD of 2/1/22 revealed she was discharged to another nursing home or swing bed on 2/1/22.

Record review of the medical chart revealed there was no written notification of transfer for Resident #67.

On 02/16/22 at 1:50 PM, during an interview with

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F 623	Continued From page 6 Social Service (SS), explained she had stopped sending a written notification of transfer to the residents' RRs about a year ago. The previous Administrator had removed that task from her responsibility because she had so much to do. She stated the nurse who initiates the resident transfer completes the transfer form and sends it along with the other information with the resident to the hospital. The facility then retains a copy of the form in the resident's medical chart. The nurses do not notify the RR in writing because the RR is notified verbally at the time of transfer. She confirmed the facility failed to notify RRs in writing of resident transfers, including the reason for the transfer. On 02/16/22 at 4:38 PM, during an interview with the Administrator, he reported that SS knew to notify the RR in writing by mailing the transfer/discharge letter to the resident's RR. On 02/18/22 at 01:47 PM, in an interview with Director of Nursing (DON), she stated SS was responsible for sending the written notice to the family. She stated she is aware that RRs did not receive written notification of the resident transfer and the forms should have been sent to the family.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 645		4/8/22

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F 645	Continued From page 7	F 645		

(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the

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F 645	Continued From page 8 hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure a Pre-Admission Screening (PASSR) Application was completed accurately for one (1) of nine (9) PASSR Applications reviewed. Resident #2. Findings Include: A record review of the facility's policy "Admission Criteria" with a reviewed date of June 2021, revealed, "Policy Statement Our facility admits only residents who's medical and nursing care needs can be met Policy Interpretation and Implementation ... 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR)	F 645	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. On 2/17/2022 the Social Services Director corrected the PASARR for Resident #2. On 02/17/2022, the Director of Nursing assessed Resident #2 and reviewed progress notes, medication list, nurses notes and most recent History and Physical from the Primary Care Provider with no concerns noted related to mental	

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F 645	Continued From page 9 process. a. the facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the level I screen indicates that the individual may meet for a MD, ID, RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) the admitting nurse notifies the social department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority." A record review of Resident #2's Admission Record revealed the facility initially admitted Resident #2 on 08/27/21 and re-admitted her on 2/3/22 with the medical diagnoses that included but were not limited to Hemiplegia and Hemiparesis following cerebral infarction, Bipolar Disorder, Unspecified and Major Depressive Disorder. A record review of Resident #2's Pre-Admission Screening (PAS) Application for Long Term Care with a PAS date of 11/5/21 revealed the application was completed by the Social Worker. "Selective Active Medical Conditions" revealed "Bipolar Disorder" which indicated the facility was aware Resident #2 had a major mental illness diagnosis of Bipolar Disorder at the time the application was completed. The answers to questions, "Person has a diagnosis of a major mental illness and has a recent history of a major mental illness" was answered "No" and indicated Resident #2 did not have a diagnosis of a major mental illness, which did not correlate with the resident's Bipolar Disorder diagnosis.	F 645	health diagnosis and current placement. All residents have the potential to be affected by the deficient practice. On 02/17/2022 the Social Services Director (SSD) stated awareness of responsibility for completion of the PASARR. The SSD voiced uncertainty on where to look for the diagnoses and was educated by the Director of Nurses (DON) and Administrator on 2/17/2022 regarding how to review the diagnosis lists in the facility electronic medical record (EMR) to ensure residents with a mental disorder and individuals with intellectual disability are recognized and related PASARR question C0100 is answered accurately. Also, concerns were voiced by SSD regarding the possibility of human error affecting accuracy which was taken into consideration by the QAC. SSD reviewed entire PASARR screening tool and verbalized understanding of section C0100. SSD return demonstrated accessing the resident EMR to review current medical diagnoses lists, recognized the error. On 03/09/2022, the Quality Assurance Committee (QAC) conducted record reviews for Resident #2 and staff interviews related to the facility Pre-Admission Screening and Resident Review (PASARR) accuracy. The QAC concluded that the facility PASARR Screening and Compliance Process was inadequate to ensure sustained compliance and the sited deficiency was related to process failure at the facility. During QAC committee meeting, Resident	

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F 645	Continued From page 10 A record review of Resident #2's Order Summary Report revealed physician orders for Zyprexa Tablet 2.5 milligram (mg) give one (1) tablet by mouth at bedtime for Bipolar Disorder, Remeron Tablet 30 mg give one (1) tablet by mouth at bedtime for Depression and decreased appetite, Paxil Tablet 20 mg give one (1) tablet by mouth one time a day related to Major Depressive Disorder. On 02/16/22 at 4:50 PM, during an interview with the Administrator, he explained the Social Worker completed PASRRs and confirmed the resident had two diagnoses of mental illness, Bipolar and Major Depression. He confirmed a PASRR II should have been sent for evaluation, but the PAS did not flag for a PASRR II due to the PAS was marked incorrectly. On 02/16/22 at 5:00 PM, during an interview with the Social Worker, she reported she did not know where to look for the diagnoses and did not know the resident had a serious mental illness. After reviewing the medical diagnoses for Resident #2, she confirmed the resident had a serious mental illness on admission of Bipolar and Major Depression. A record review of Resident #23's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/9/22 revealed diagnoses of Bipolar Disorder and Depression and received seven days of antipsychotic and antidepressant medications during the seven day look back period.	F 645	#2 diagnosis list was reviewed along with History and Physical and progress notes from providers. QAC deemed Resident #2 to require services provided by a nursing home related to diagnosis other than mental disorder. Pt noted to have long standing history of mental health diagnosis but actual date of initial diagnosis of mental disorder is unknown, and described as "most of her life" per Resident Representative. Resident #2 also has been appropriately followed by a Psychiatric Nurse Practitioner since admission and was last seen by the Psychiatric Nurse Practitioner on 02/15/2022 for a routine visit. On 03/09/2022 facility QAC adopted a new process to ensure PASARR screening is completed accurately and compliance is sustained. Beginning 3/9/2022, upon completion of any PASARR, the SSD will deliver the PASARR to the DON or Registered Nurse for review to ensure accuracy. Once the PASARR is approved by the DON or Registered Nurse, the PASARR information will be submitted electronically. At the time of review by DON or RN, any variances discovered, related to the accuracy of the PASARR documentation, will be discussed with the SSD and facility Administrator. Errors will be immediately corrected prior to electronic submission. This will be an ongoing process. Beginning 3/9/2022, all variances will be logged on the PASARR Variance Log (log) by the Administrator. The logged variances will be reported to the QAC on	

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F 645	Continued From page 11	F 645	4/04/2022 and quarterly thereafter for 2 quarters beginning 05/04/2022 for review by the Medical Director and the Steering Committee to ensure sustained compliance.	
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 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	F 690		4/8/22

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	255297	A. BUILDING _____ B. WING _____	02/18/2022

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F 690	Continued From page 12 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, interviews, record review and facility policy review, the facility failed to ensure catheter tubing was anchored to minimize movement or prevent friction and trauma during catheter care and failed to provide catheter care in a manner to prevent infection for one (1) of three (3) catheter care observations. Resident #13. Findings include: The facility policy, "Catheter Care, Urinary", revised September 2014 and reviewed 1/2022 revealed, "Purpose The purpose of this procedure is to prevent catheter-associated urinary tract infections ...Infection Control ...2a Routine hygiene (e.g. to maintain routine hygiene cleansing of the meatal surface during daily bathing or showering is appropriate) ... The staff should assess the urethral meatus prior to providing care. For a female resident use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward, cleansing strokes. Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethra meatus. Do not allow the washcloth to drag on the resident skin or bid linen. With a clean washcloth, rinse with warm water using the above technique. The staff may use incontinent wipes. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to	F 690	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. Resident #13 was assessed for trauma and any signs and symptoms of infection by the Director of Nursing on 02/16/2022. Resident #13 does not appear to be affected by the deficient practice at this time but nursing staff will continue to monitor for any signs of trauma and infection. All residents have the potential to be affected by the deficient practice. On 03/08/2022, the Quality Assurance Committee (QAC) conducted record reviews and staff interviews related to the finding identified during urinary catheter care and perineal care observations on 02/18/2022 stated in the Statement of Deficiencies. The QAC concluded that current facility policies and procedures are adequate to meet current regulatory compliance. The findings identified were related to staff not following facility policy	

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F 690	Continued From page 13 approximately 4 inches outwards." During an interview on 2/16/22 at 3:45 PM, Resident #13 revealed the staff needs to be gentle when providing catheter care, because her catheter has come out several times. During an observation on 2/16/22 at 4:00 PM, of catheter/perineal care, Certified Nursing Assistant (CNA) #1 wiped down the center of the resident's vaginal area three times with the same side of the wet wipe. CNA #1 pulled out another wipe and went down the left side of the vaginal area with the same wipe three (3) times. CNA #1 pulled outward on the tubing without securing the tip near the meatus. During an interview on 2/16/22 at 4:15 PM, with CNA #1, she confirmed she failed to change wipes with each stroke while providing perineal care. CNA #1 also confirmed she failed to secure the tubing at the meatus. CNA #1 said she did not realize the tubing would come out by pulling on it. During an interview on 02/18/22 at 12:08 PM, with the Director of Nursing (DON), she confirmed CNA #1 failed to follow the facility policy by wiping the resident's vaginal area with the same wipe, without changing the position of the wipe. The DON also said CNA #1 should have secured the tubing at the meatus to prevent trauma or friction and the staff is trained to wipe one time and discard the wipe and trained to secure the tubing to prevent trauma or friction. The DON confirmed this could cause the resident to get an infection. The DON also confirmed Resident #13's catheter has come out several times. During an interview on 2/18/22 at 12:25 PM,	F 690	and procedure as trained and instructed. In-service training began on 03/02/2022 and was completed on 03/11/2022 which included Urinary Catheter Care and Perineal Care conducted by the Staff Development Nurse or Registered Nurse for all Certified Nursing Assistants to ensure facility policy and procedure are followed to reduce the risk of trauma and infection. Ten catheter care and/or perineal care observations will be conducted by the Staff Development Nurse or Registered Nurse weekly for 2 weeks beginning 3/14/2022 and then ten observations monthly for 8 weeks beginning 03/28/2022. All variances observed will be immediately corrected, policy and procedure related to the variance will be reviewed and the CNA responsible for the variance will verbalize and return demonstrate the appropriate policy and procedure related to the deficient practice. All variances and retraining will be documented and filed for reference. All urinary catheter care and perineal care observation variance documentation will be reported to the QAC initially on 4/4/2022 and quarterly thereafter for 2 quarters beginning 5/4/2022 for review by the Medical Director and the Steering Committee to ensure sustained compliance.	

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F 690	Continued From page 14	F 690		

Registered Nurse (RN) #2 confirmed CNA #1 failed to follow the Catheter/perineal policy. RN #2 said CNAs are trained to wipe one time with the wipe and to discard it. They are also trained to secure the tubing of the catheter at the meatus to prevent trauma and pulling the catheter out. RN #2 stated this could cause infection and trauma. RN #2 confirmed the resident's catheter has come out several times.

Record review of the "Admission Record" revealed the facility admitted Resident #13 on 07/08/2016, with diagnoses including Chronic Cystitis without hematuria, Urinary Tract Infection and Neuromuscular Dysfunction of Bladder.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/21, revealed Resident #13 had a Brief Interview of Mental Status (BIMS) score of 15 that indicated Resident #13 is cognitively intact.

Record review of the facility's "Order Summary Report" with active orders as of 2/18/22 revealed Resident #13 had physician orders to perform catheter care as needed and "Catheter Orders as needed if the catheter is pulled out with bulb inflated, reinsert immediately with 24 Fr (french) 30 cc (cubic centimeters) balloon, and monitor for excessive bleeding. Monitor Resident for elevation in temperature or chills. If present, notify physician".

Record review of the facility's education sheet, titled "Provides Catheter Care Skills Sheet", dated 6/6/21 revealed CNA #2 was trained on catheter care "For Females: holds catheter near meatus two avoid tugging the catheter. Use wipe to

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F 690	Continued From page 15 cleanse the labia. Use one area of the wipe for each downward, cleansing stroke. Change position of wipe or obtain new wipe and cleanse around urethral meatus. Cleanse at least 4 inches of catheter nearest meatus, moving in only one direction (i.e. away from the meatus) using a clean area of the wipe for each stroke or obtain new wipe."	F 690		
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 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	F 880		4/8/22

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F 880	Continued From page 16 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. §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 observations, interviews and facility	F 880	Bedford Care Center-Monroe Hall, LLC	

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F 880	Continued From page 17 policy review, the facility failed to prevent the possible spread of infection during medication administration and Percutaneous Endoscopic Gastrostomy (peg) site care for five (5) of seven (7) observations. Findings Include: Record review of the facility's policy, "Hand washing/Hand Hygiene", with a revised date of August 2015 and reviewed date of 10/2021 revealed, "Policy Statement The facility considers hand hygiene the primary means to prevent spread of infections. Policy Interpretation and Implementation ...7. Use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ... 7.b. Before and after direct contact with residents. 7.c. Before preparing or handling medications; ...7. m. After removing gloves ..." On 2/17/22 at 8:23 AM, during an observation of medication pass, Licensed Practical Nurse (LPN) #2 left the medication cart with an uncovered cup of medications for Resident #31 in her left hand and some crackers in a cup in her right hand. LPN #2 entered Resident #19's room and gave her crackers and exited the room without washing or sanitizing her hands and continued to hold Resident #31's uncovered medications in a cup in her right hand. She then entered Resident #31's room and gave her the medication that was in the cup. LPN #2 exited Resident # 31's room and returned to medication cart and prepared medications for Resident #47. LPN #2 did not wash or sanitize her hands before preparing Resident #47's medications. LPN #2 entered Resident #47's room holding an Oxygen (O2)	F 880	(facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. The observed practice by LPN#2 is not a reflection of the current facility policy and procedure. LPN #2 was immediately trained on 02/16/2022 regarding facility infection control, infection prevention, and medication administration policy and procedure by the Director of Nursing. LPN#2 was able to verbalize and return demonstrate the facility policies and procedures related to medication pass and infection control variances observed. All residents have the potential to be affected by the deficient practice. On 03/09/2022, the Quality Assurance Committee (QAC) conducted record reviews and staff interviews related to the variances identified during medication pass documented on 02/17/2022 stated in the Statement of Deficiencies. A Root Cause Analysis (RCA) was conducted on 3/09/2022 by the QAC and Quality Assurance and Performance Improvement (QAPI) team. The QAC and QAPI team concluded that the facility Infection Control and Prevention Policy related to Hand Hygiene and Medication Administration is adequate to ensure appropriate measures are taken to	

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F 880	Continued From page 18 pulse oximetry device, resident medications, and a temple thermometer. She applied the O2 pulse oximeter to Resident #47's right finger. She then used the temple thermometer to obtain the resident's temperature. She placed the O2 pulse oximeter and the thermometer on a bedside table without a barrier. She donned one glove on her right hand and administrated the nasal spray medication. She removed the glove before exiting the room but did not wash or sanitize her hands. LPN #2 returned to the medication cart and opened a new box of disinfectant wipes by removing the top lid and placed the wipes in her bare hand and pulled them apart. She used a disinfectant wipe to clean the O2 pulse oximeter and used the same wipe to clean the thermometer. She used another wipe to clean her hands but did not use alcohol-based hand rub or soap. LPN #2 then prepared medications for Resident #50. She entered Resident #50's room and placed the thermometer and O2 pulse oximeter on the resident's bedside table and did not apply a barrier. She then gave the medications in the cup to the resident, and she spilled the medications on her bed and one pill rolled onto the floor. Resident #50 picked up the medications off the bed and placed them in the cup. LPN #2 took the cup of medications from the resident and picked up a pill identified as Dicyclomine HCl off the floor. LPN #2 then went to the medication cart, disposed of the pill in the sharps container, and retrieved another Dicyclomine HCl pill and did not wash or sanitize her hands before handling the medication. She went back into Resident #50's room and gave her the cup of medications that included the ones that had fallen onto the residents' bed. Resident #50 took the medications in the cup. LPN #2 exited the room and sanitized the equipment with a	F 880	prevent the spread of infection during medication pass. The variances observed were related to staff not following facility policy and procedure as trained and instructed in recently completed in-service training completed by LPN#2. QAC and QAPI team reviewed the CDC training videos titled, "Clean Hands" and "Sparkling Surfaces", and these videos were adopted as part of the Infection Prevention and Control training plan for this plan of correction. Training of all nursing staff Licensed Practical Nurses (LPN) and Registered Nurses (RN) on the topics of Hand Hygiene, Infection Control and Prevention, and Medication Administration began on 03/09/2022 and documentation of all LPN and RN staff training was completed on 03/12/2022. The Staff Development nurse or RN will conduct hand hygiene observation and medication administration observation two times per week for eight weeks starting on 3/09/2022. The Infection Preventionist or RN will conduct focused infection control rounds related to hand hygiene and medication pass procedure no less than two times a week for eight weeks beginning on 3/09/2022. All variances observed will be immediately corrected, policy and procedure related to the variance will be reviewed and the nurse observed out of compliance will verbalize and return demonstrate the appropriate policy and procedure related to the deficient practice. All variances and retraining will be documented and filed for reference.	

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F 880	Continued From page 19 disinfectant wipe and wiped her hands with another wipe. On 2/17/22 at 10:45 AM, in an interview with LPN #2, stated she should have not taken Resident #31's medications into Resident #19's room. She stated she did not sanitize her hands between Resident #19's and Resident #31's rooms. She stated when she cleaned the equipment, she should have used one disinfectant wipes per item. She also confirmed she should have sanitized her hands each time before handling medications. She stated that her actions can cause cross contamination and cause the resident to have an infection and infections can be life threatening. On 2/17/22 at 3:46 PM, in an interview with Registered Nurse (RN) #1, she stated LPN #2 transferred what was on the equipment to the next resident She confirmed LPN #2 should have washed her hands before and after contact with each resident. She stated the pills that had fallen onto the bed should been discarded and the nurse should have prepared a new set of pills because the pills were contaminated. She stated LPN #2's actions can cause infection to spread from resident to resident. On 2/17/22 at 4:15 PM, in an interview with the Director of Nursing (DON) stated LPN #2 should have discarded the medications and prepared new medications after the resident wasted it on the bed. She also confirmed LPN #2 should have washed or sanitized her hands before and after resident contact. She stated LPN #2's actions put the resident at risk for infection. Resident #53	F 880	All hand hygiene, medication administration, and infection control observation variance documentation will be reported to the QAC and QAPI initially on 4/4/2022 and quarterly thereafter for 2 quarters beginning 5/4/2022 for review by the Medical Director and the Steering Committee to ensure sustained compliance.	

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F 880	Continued From page 20 On 2/16/22 at 10:30 AM, during a medication administration observation, LPN #1 checked placement of Resident #53's Percutaneous Endoscopic Gastrostomy (peg) tube and did not remove gloves after checking placement and before administering medication per the peg tube. After administering the medication by peg tube, she removed her gloves and applied clean gloves, but did not wash or sanitize her hands before applying clean gloves. LPN #1 then realized that she did not have glucose test strips needed to perform an accucheck. LPN #1 exited the room, wearing gloves, and went down the hallway and retrieved a test strip from the medication cart drawer, opened the bottle to retrieve the strip and returned to the resident's room while still wearing the same gloves. LPN #1 checked Resident #53's blood sugar by wiping his right index finger with a clean alcohol wipe, pricked the resident's finger with a lancet, and obtained blood sample with test strip, while wearing the same gloves. LPN #1 opened an alcohol prep and cleaned the top of an insulin vial with the alcohol prep and drew up 15 units of insulin with her right hand while still holding the used alcohol prep in her left hand. LPN #1 used the contaminated alcohol prep to clean the left lower abdomen of the resident. LPN #1 administered the insulin and removed her gloves. She then applied clean gloves without washing or sanitizing her hands and cleaned the resident's peg site. After the procedure, she washed her hands, gathered supplies and barrier, and exited the room. On 2/16/22 at 2:05 PM, in an interview with LPN #1, she stated she should have washed her hands before applying clean gloves each time.	F 880		

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She confirmed she should have removed her gloves before entering the hallway and her actions placed the resident at risk for infection. LPN #1 also verified she should have not cleaned the insulin injection site with the same wipe she had used to clean the top of the insulin vial. She stated she has had training on infection control and handwashing practices.

On 2/17/22 at 3:25 PM, in an interview with RN #1/Infection Preventionist, she confirmed that LPN #1 should have washed her hands each time she removed her gloves, and she should have not been in the in the hallway with gloves on. LPN #1 should have made sure she had all supplies before beginning care and should have used another alcohol prep for the insulin injection instead of using the one she had used to clean the insulin vial. She stated these practices could have caused the resident to acquire a serious infection.

On 2/17/22 at 4:00 PM, in an interview with the DON, she stated LPN #1 should have sanitized hands and changed gloves after checking for peg tube placement. The DON stated by the facility policy, LPN #1 should have used a new alcohol prep to clean the insulin injection site and she should have sanitized her hands after removing her gloves each time. She stated LPN #1 put the resident at risk for infection.

Record review of a facility education form dated 1/12/22, with the "Class Name" listed as "Med Administration", revealed LPN #1 and LPN #2 signed the in-service which indicated both nurses received training on medication administration.

Record review of a facility education form dated

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F 880	Continued From page 22 12/7/21, with the "Class Name" listed as " ...Hand Hygiene", revealed LPN #1 signed the in-service which indicated she received training on hand hygiene.	F 880		