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
	18BC	A. BUILDING: _____ B. WING _____	C 01/27/2023

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BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS #20570 at the facility from 1/26/23 through 1/27/23. The complaint was related to verbal abuse, resident grooming, neglect, infection control, administration, and resident incontinence care. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500 and M610.	M 000		
M 500	45.17.2 Residents' Rights 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	M 500		2/17/23

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M 500	Continued From page 1 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; 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	M 500		

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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 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 observation, interview, record review, and facility policy review, the facility failed to ensure reasonable accommodation was provided to a resident when his call light device was not	M 500	Bedford Care Center - Monroe Hall, LLC 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 the applicable rules and	

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M 500	Continued From page 4 within reach for one (1) of seven (7) sampled residents. Resident #2 Findings include: Record review of the facility policy titled "Call Lights: Accessibility and Timely Response, revised 8/2/22, revealed, "Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside ...to allow residents to call for assistance ...Policy Explanation and Compliance Guidelines: 1. All staff will be educated on the proper use of the resident call system including ...ensuring resident access to the call light ...5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room ..." On 1/26/23 at 11:05 AM, during an observation and an interview with Resident #2, he was lying in bed and his call light device was hung over the headboard of the bed. Resident #2 reported that he was not able to reach the call light whenever it was placed over the headboard and that it was not unusual that it was not in his reach. He stated, "I don't even worry about it anymore." On 1/26/23 at 1:30 PM and at 5:00 PM, during an observation and an interview with Resident #2, the call light device continued to be positioned hanging over the headboard out of his reach. Resident #2 reported that it had been out of his reach and had not been moved. On 1/27/23 at 10:10 AM, 11:50 AM, and 1:24 PM during observations, the call light device for Resident #2 remained positioned on the bed's	M 500	regulations. Please accept this Plan of Correction as our credible allegation of compliance. The call light for Resident #2 was placed within easy reach on 1/27/2023. All Residents have the potential to be affected by the deficient practice. All staff were in-serviced on the facility□s call light accessibility policy by the Staff Development Nurse beginning on 1/27/23 and was completed on 2/9/23. The Quality Assessment and Assurance Team began making call light rounds on 1/30/23 five times per week and this will be an ongoing process. Registered Nurse Supervisor will make rounds two times daily for one week beginning 2/13/23, then daily for one week beginning 2/20/23. Rounds will be made by the Registered Nurse Supervisor three times per week for two additional months ending on 4/14/23 to ensure sustained compliance. Variances observed during rounds will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting initially on 2/17/23 and then monthly beginning on 3/17/23 and ending on 4/14/23 to ensure sustained compliance.	

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M 500	Continued From page 5	M 500		

headboard, which was behind and out of reach of the resident. Resident #2 confirmed that he was not able to reach the call light and that it had not been moved although several staff members had entered his room on 1/27/23. He expressed that it was "frustrating" that the staff did not reposition the call device when they were in his room.

On 1/27/23 at 2:00 PM, during an interview with the Staff Development Nurse (SDN), he confirmed that call lights were "supposed to be in the residents' reach".

On 1/27/23 at 2:15 PM, during an observation and an interview with Resident #2, the call light device was laying on the bed beside the resident and within his reach. Resident #2 stated, "Yeah, they finally decided to give it to me.".

On 1/27/23 at 3:40 PM, during an interview the Director of Nursing (DON), she confirmed that staff were "supposed to" leave the resident's call light within their reach each time they left a resident's room.

On 1/27/23 at 3:50 PM, during an interview with the facility's Administrator, he stated that staff should place call lights within a resident's reach upon completion of care.

Record review of the "Admission Record" for Resident #2 revealed he was admitted by the facility on 6/04/21 with diagnoses including Orthostatic Hypotension, Atrial Fibrillation, and Dementia.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/11/23 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of

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M 500	Continued From page 6 10, which indicated he had moderate cognitive impairment. Further review of the MDS revealed that he required extensive assistance for transfers.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents, who were unable to carry out Activities of Daily Living (ADLs), received the necessary services to maintain grooming and personal hygiene for four (4) of seven (7) sampled residents. Resident #1, Resident #3, Resident #5, and Resident #7. Findings Include: Record review of the facility's policy, "Care of Fingernails/Toenails", revised 8/2/22, revealed, "The purposes of this procedure are to clean the nail bed, to keep nails trimmed ...1. Nail care includes daily cleaning and regular trimming ...13.	M 610	Bedford Care Center - Monroe Hall, LLC 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 the applicable rules and regulations. Please accept this Plan of Correction as our credible allegation of compliance. Residents #1, #3, #5, and #7 received nail care which included trimming by the Wound Care RN on 1/26/23. All Residents have the potential to be affected by the deficient practice. All nursing staff were in-serviced on	2/17/23

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M 610	Continued From page 7 Trim fingernails in an oval shape and toenails straight across. 14. Smooth the nails with a nail file or emery board ..." Record review of the facility's policy, "Activities of Daily Living (ADLs), Supporting Policy", revised 8/2/22, revealed, "Policy Interpretation and Implementation ...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently ...including appropriate support and assistance with: a. hygiene (...grooming ...) ..." Resident #1 On 1/27/23 at 10:25 AM, during an observation with the Wound Care Nurse, Resident #1's toenails were long and ragged/jagged and his fingernails were long, jagged. The length of Resident #1's fingernails exceeded the tips of the fingers on his right hand 0.2 centimeters to 0.4 centimeters. On 1/27/23 at 10:30 AM, during an interview with the Wound Care Nurse, she described the toenails of Resident #1 as "long and ragged". She confirmed Resident #1's fingernails were also long. She reported that fingernail care and toenail care were included in adequate grooming for residents. She also confirmed the resident was not able to trim his own fingernails or toenails and it was the responsibility of the resident's nurse or herself to provide toenail care. She stated the Certified Nurse Aides (CNAs) were responsible for reporting to the nurses if a resident's toenails or fingernails needed to be trimmed. Record review of the "Admission Record" for Resident #1 revealed the facility admitted him on 6/23/10, with diagnoses including Hemiplegia and	M 610	proper nail care by the Staff Development Nurse and in-serving was completed by 2/13/23. The Quality Assessment and Assurance Team began making call light rounds on 1/30/23 five times per week and this will be an ongoing process. The Wound Care Registered Nurse will evaluate nail care for residents with high risk conditions weekly beginning 2/13/23 and the Medication Nurses will evaluate nail care for all other residents weekly beginning 2/13/23. The Director of Nursing, or Registered Nurse, will conduct nail care observations of at least 5 residents per week for 2 months beginning 2/17/23 and ending 4/14/23. Variances noted during nursing evaluations will be monitored at the monthly Quality Assessment and Assurance Committee meeting initially on 2/17/23 and then monthly beginning on 3/17/23 and ending on 4/14/23 to ensure sustained compliance.	

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M 610	Continued From page 8 Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Parkinson's Disease, and Type 2 Diabetes Mellitus. Record review of the quarterly Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 12/21/22 revealed the resident had a Brief Interview for Mental Status (BIMS) score of "00" and documented the resident exhibited "Disorganized Thinking ...incoherent ...unclear flow of ideas" and "Altered Level of Consciousness". Further MDS review revealed Resident #1 required extensive assistance with personal hygiene. Resident #3 On 1/26/23 at 1:40 PM observation and an interview with Resident #3 in her room revealed she was seated in a wheelchair in her room reading a book. She had the appearance of being neat, appropriately dressed, and free of malodorous smells. Her fingernails were long and dirty. Her fingernails extended approximately 0.5 centimeters past the end of her fingers and were jagged, rough, and not smooth. Record review of the "Admission Record" for Resident #3 revealed the facility admitted her on 5/17/22 with diagnoses including Toxic Encephalopathy and Type 2 Diabetes Mellitus. Record review of the quarterly MDS with an ARD of 11/09/22 revealed Resident #3 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. Further review of the MDS, Section G, revealed Resident #3 required extensive assistance with personal hygiene.	M 610		

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M 610	Continued From page 9	M 610		

Resident #5

On 1/27/23 at 10:55 AM, an observation revealed the resident had long, rough, jagged toenails.

Record review of the "Admission Record" for Resident #5 revealed she was admitted by the facility on 5/09/22 with diagnoses including Alzheimer's Disease and had Dementia.

Record review of the quarterly MDS with an ARD of 11/02/22 revealed the resident had a BIMS score of "00" with documentation of "Delirium ...Inattention". Further MDS review, Section G, revealed Resident #5 required extensive assistance with personal hygiene.

Resident #7

On 1/27/23 at 11:10 AM, an observation revealed Resident #7 was seated in a wheelchair at a table in a common area. Both of her hands were balled up into tight fists and appeared to be contracted. With the assistance of the Director of Nursing (DON) the resident's fingernails were assessed and noted to be long, rough, and jagged.

On 1/27/23 at 11:15 AM, during an interview the DON, she confirmed that Resident #7's fingernails were long. She said that fingernails and toe nails were to be assessed by nurses and CNAs on an ongoing basis and fingernail and toenail care should be provided by staff as needed. She confirmed that there were criteria for CNAs to be able to use clippers to trim fingernails or toenails, but the CNAs responsibility included reporting to the nurse if a resident needed care and they were not able to provide the care.

Record review of the "Admission Record" for

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M 610	Continued From page 10 Resident #7 revealed she was admitted by the facility on 5/19/17 with diagnoses including Alzheimer's Disease and Dementia. A record review of the quarterly MDS with an ARD of 12/7/22, revealed Resident #7 had long and short term memory problems and her cognitive skills for daily decision making was severely impaired. Further MDS review,Section G, revealed Resident #7 required extensive assistance with toilet use and personal hygiene. On 1/26/23 at 2:30 PM, during an interview with CNA #4, she reported that the facility provided in-service training for ADLs. On 1/26/23 at 3:00 PM, during an interview Registered Nurse (RN) #1, she stated she was responsible for supervision of Licensed Practical Nurses (LPNs) and the care of residents. She stated the CNAs were trained and reminded and provided with instruction to use and follow the "Kardex" in electronic health records software for ADL care. She confirmed that staff were expected to provide care based on the MDS assessment of each resident which was reflected in the resident's Kardex. She reported each resident was scheduled for showers every week, most every other day, and that fingernail care was "supposed to be done on shower days". She said that if a resident was diabetic, had physician orders for anticoagulant therapy or was diagnosed with a bleeding disorder, the CNA should report to a licensed nurse if the resident's nails needed trimming, but they were allowed to use an emery board as needed to file or smooth any resident's nails. On 1/27/23 at 2:00 PM during an interview the Staff Development Nurse (SDN), he stated that	M 610		

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M 610	Continued From page 11 he was responsible for "general facility orientation for CNAs and for checkoff competencies for CNAs when they are ready to be own their own". He confirmed the competencies included ADL care. He confirmed that all CNAs employed by the facility had received formal training in a certified training program which would have included correct ADL procedures. On 1/27/23 at 3:40 PM, an interview with the DON, she confirmed the nursing staff were responsible for assessment of the condition of resident fingernails and toenails and provide fingernail and toenail care as appropriate to prevent the fingernails and toenails from growing too long or being rough or jagged. She confirmed that fingernail care and toenail care were included in personal hygiene and grooming. On 1/27/23 at 3:50 PM, an interview with the facility Administrator, he confirmed the nursing staff were responsible for fingernail care and toenail care and that fingernail care and toenail care was considered personal hygiene/grooming.	M 610		