

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255297	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/27/2023
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CTR-MONROE HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CAHAL STREET HATTIESBURG, MS 39401		
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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and a Complaint Investigation (CI), MS #20570, was conducted by the State Agency (SA) at the facility from 1/26/23 through 1/27/22. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 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 requirements for participation in Medicare and Medicaid and cited F677 and F690. The SA additionally cited F558 which was not related to the CI.	F 000			
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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,	F 677	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	2/17/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 677	Continued From page 1 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. 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	F 677	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 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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F 677	Continued From page 2 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 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, Section G, 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. 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.	F 677			

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F 677	Continued From page 3 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. 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. 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	F 677			

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F 677	Continued From page 4 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 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	F 677			

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F 677	Continued From page 5 "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 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.	F 677			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		2/17/23	

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F 690	Continued From page 6 §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 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 that a resident, who was incontinent of	F 690	Bedford Care Center - Monroe Hall, LLC acknowledges receipt of the Statement of Deficiencies and proposes this Plan of		

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F 690	Continued From page 7 bladder received appropriate treatment and services to prevent urinary tract infections (UTIs) for one (1) of two (2) incontinence care. Resident #3 Findings include: Record review of the facility's policy, "Perineal Care" revised 8/2/22, revealed, "The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections ... 10 ... e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks (wipe from front to back) ..." On 1/27/23 at 12:00 PM, during an interview the Resident Representative (RR) for Resident #3 expressed concern related to the incontinence care provided for Resident #3 and that she was considering other facilities because she was not satisfied. She stated that she was worried because Resident #3 had previously been diagnosed with UTI, however, the resident did not actively have an infection. On 1/27/23 at 1:49 PM, during observation of incontinence care for Resident #3 performed by Certified Nurse Aide (CNA) #1 and CNA #2, with the Staff Development Nurse (SDN) present in the room, CNA #1 used a disposable cleansing cloth and wiped from the rectal area toward the vaginal area (back to front) of the resident. On 1/27/23 at 1:55 PM, during an interview with CNA #1, she stated that she was aware she had made a mistake during incontinence care, and she stated "I got nervous; I wiped from back to front. I know better." She confirmed she knew that the correct procedure was to cleanse or wipe	F 690	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. Resident #3 was assessed for trauma and any signs or symptoms of infection by the Director of Nursing on 1/27/23 with no negative outcomes observed. All Residents have the potential to be affected by the deficient practice. In-service training began on 1/27/23 and was completed on 2/9/23 with included Incontinence and Perineal Care conducted by the Staff Development Nurse for all Certified Nursing Assistants to ensure facility policy and procedure are followed to reduce the risk of trauma and infection. 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. Five perineal care observations will be conducted by the Staff Development nurse weekly for two weeks beginning 2/13/23 and then beginning 2/27/23 five observations monthly for 2 months ending 4/14/23. All perineal care observation variance documentation will be reported to the 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		

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F 690	Continued From page 8 front to back to prevent urinary tract infections. On 1/27/23 at 2:00 PM, during an interview the SDN, he confirmed that he also had witnessed during the SA observation CNA #1 perform incontinence care for Resident #3 and that she had cleaned the resident by wiping from back to front, which did not coincide with the facility policy or current standards of practice designed to prevent urinary tract infections and it could have potentially lead to the resident obtaining a urinary tract infection. On 1/27/23 at 3:40 PM, during an interview the Director of Nursing, she confirmed that facility policy and accepted current standards of care specified that incontinence care should always include cleansing (wiping) from front to back and that for female residents that meant the vaginal area toward the rectal area, and never back to front. She stated that in-service training had been provided for all nursing staff in which facility incontinence care policy and procedure and current standards of care designed to prevent urinary tract infection were reviewed. She confirmed use of incorrect procedure could potentially lead to urinary tract infection. 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 Assessment Reference Date (ARD) of 11/09/22 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Further review revealed Resident #3	F 690	sustained compliance.		

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F 690	Continued From page 9 required extensive assistance with toilet use and personal hygiene and was assessed as "Always Incontinent" for Urinary Continence and "Always Incontinent" for Bowel Continence.	F 690			