STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255343	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PICAYUNE	2797 COOPER ROAD PICAYUNE, MS 39466

(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 recertification survey from 9/3/19 through 9/5/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid requirements of participation. The SA cited F640, F656, and F880 The facility census was 56 and the facility was licensed for 60 beds at the time of survey.	F 000		
F 640 SS=C	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within	F 640		9/27/19

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

Electronically Signed | 09/20/2019

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 640	Continued From page 1 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit Minimum Data Set (MDS) assessments within the 14 day requirements for two (2) of two (2) residents reviewed for encoding and submission of the MDS, Resident #1 and Resident #2. Findings include: A review of the facility policy titled, "MDS Completion and Submission Timeframes", with a revised date of September 2010, revealed the discharge assessment -return not anticipated assessment to be submitted by 14 days from the Minimum Data Set (MDS) completion date.	F 640	F640 Minimum Data Set (MDS) Nurse submitted the discharge assessments on 9-20-2019 for Residents #1 and #2. All residents have the potential to be affected. The Interdisciplinary Team will meet weekly to review that all transmissions including discharges assessments are completed and submitted timely beginning on 9-25-2019. The Administrator in-serviced the MDS nurse on submitting	

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F 640	Continued From page 2 A review of Resident #1's MDS with an Assessment Reference Date (ARD) of 5/17/19, revealed a discharge of 5/17/19, to the community. The MDS was not submitted until after July 2019. A review of Resident #2's MDS with ARD of 5/29/19, revealed a discharge date of 5/29/19, to an acute care hospital. The MDS was not submitted until after July 2019. An interview on 09/05/19 at 11:16 AM, with Licensed Practical Nurse (LPN)#2/MDS Nurse, revealed she could not locate the validation reports related to Resident #1 or Resident #2's MDS. LPN #2 stated when the facility changed systems, these would not have been brought over because they were prior to July. She said their in-house audit caught a batch of discharges that were not sent and had to be re-submitted in July of 2019. She said that these two (2) discharges would have been in that submission. LPN #2 confirmed the policy for the facility was to submit within 14 days, but was not done until July, when the audit caught the discrepancy.	F 640	discharge assessments timely on 09-20-2019. The Director of Nursing (DON) will perform weekly audits on patients to ensure that the MDS assessments are submitted timely starting on 09-25-2019. These results will be evaluated by the Quality Assurance and Assessment (QAA) committee for effectiveness and changes will be made as recommended by the QAA committee. The corrective actions will be completed by 9-27-2019.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		9/27/19

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F 656	Continued From page 3 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to develop a care plan related to weight loss for one (1) for 18 resident care plans reviewed, Resident #62.	F 656	F656 Director of Nursing (DON) corrected Resident #62's individualized comprehensive person centered plan of care on 9-05-2019 to address their	

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F 656	Continued From page 4 Findings include: A review of the facility's policy titled "Care Plans-Comprehensive", with a revision date of March 2017, revealed an individualized comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Our facility's Care Planning/Interdisciplinary Team develops and maintains a comprehensive person-centered care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Review of Resident #62's current Care Plan revealed no documentation of weight loss or interventions to help prevent weight loss. Review of the medical record revealed Resident #62's admission weight on 6/14/19, was 154.0 pounds (lbs.), her weight on 6/25/19 was 145.80 lbs., on 7/4/19 138.0 lbs., on 7/23/19 133.20 lbs, on 8/6/19 135 lbs. on 8/25/19 140.6 lbs, and on 9/3/19, Resident #62's weight was 141.0 lbs. This was a 13 lb weight loss in three (3) months. A review of the most recent Medicare 30 day Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/29/19, was coded to include an unprescribed weight loss. On 9/03/19 at 11:30 AM, an observation revealed, Resident #62 sitting in the dinning room waiting on her lunch. At 11:33 AM, Resident #62 stated when she was getting sick, she had lost her appetite. She stated the food is good here.	F 656	unplanned weight loss and fluctuations in this residents weight related to the use of diuretics and recent hospitalizations. All residents who have unplanned weight loss have the potential to be affected. The Interdisciplinary Team will meet weekly to review our residents' weights starting on 9-25-2019. The Dietary Manager will create and/or update the care plan of any resident that has a significant unplanned weight loss. The DON/Staff Development Nurse will perform weekly audits starting 9-25-2019 of all residents' weights to ensure that an individualized comprehensive person centered plan of care to address their unplanned weight loss is present. These results will be evaluated by the Quality Assurance and Assessment (QAA) committee for effectiveness and changes will be made as recommended by the QAA committee. The corrective actions will be completed by 9-27-2019.	

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F 656	Continued From page 5 On 9/03/19 at 11:44 AM, an observation revealed Resident #62 had noodles with beef tips, carrots, roll, cole slaw, slice of cake, cranberry juice, and water on her meal tray for lunch. She was observed feeding herself. At 12:00 PM, Resident #62 was observed to have eaten all of her meal. A record review of the physician orders, for Resident #62, revealed an order date of 7/28/19, indicated a Limited Concentrated Sweets (LCS)/No Added Salt (NAS) Regular Diet with regular texture and regular consistency. On 9/04/19 at 11:57 AM, an interview with the Director of Nursing (DON) revealed the resident was on dialysis when she was first admitted to the facility. Upon further interview, on 9/04/19 at 2:11 PM, the DON stated the facility discusses the resident's weight every Thursday. She stated Resident #62 was on dialysis when she was admitted and when the resident had come off dialysis she had some more weight loss. The DON also sated the dialysis unit sent Resident #62 to the hospital and she had a pacemaker put in. The DON stated Resident #62 had just returned from the hospital again this past Saturday and her weight had been up and down. She stated the resident has diagnoses of Congested Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) and the hospital had diuresed Resident #62, so she had lost some more weight. On 9/05/19 at 11:58 AM, an interview with the DON revealed she is responsible for the care planning process. She also stated she did not see a weight loss care plan for Resident #62, and she guessed she did not do it.	F 656		

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F 656	Continued From page 6 A review of the facility's Face Sheet revealed, the facilty admitted Resident #62 on 7/3/19, with a diagnosis of CHF.	F 656		
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 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		9/27/19

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F 880	Continued From page 7 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 observation, staff interview, record review, and facility policy review, the facility failed to prevent the possible spread of infections related to wound care for one (1) of three (3) wound care observations, Resident #18; and	F 880	F880 The Director of Nursing (DON) assessed Resident #39 and #18 on 9-05-2019 for signs and symptoms of infection and none	

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F 880	Continued From page 8 related to medication administration for one (1) of five (5) residents observed during medication pass, Resident #39. Findings include: A Review of facility policy titled "Infection Control Guidelines for All Nursing Procedures" dated September 2012 revealed, "the facility is to provide guidelines for general infection control while caring for residents". A review of facility policy titled, "Administering Medications" dated March 16, 2019 revealed, "Medications shall be administered in a safe and timely manner, and as prescribed. Staff shall follow established facility infection control procedures (e. g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications". Resident #39: An observation on 09/03/19 at 11:30 AM, revealed Licensed Practical Nurse (LPN) #1 entered Resident #39's room and placed a paper towel on the over-bed table. LPN #1 placed a syringe and alcohol prep on the barrier and then sat the multi-dose bottle of Novolog Insulin on the over bed table, but not on the barrier. LPN #1 washed her hands in Resident #39's bathroom, used a paper towel to dry her hands, and then used the same paper towel to turn the faucet off. LPN #1 returned to the over bed table, gloved, wiped the top of the multi-dose Insulin bottle with an alcohol prep, and drew up 15 units of Novolog Insulin. LPN #1 sat the insulin bottle on the over-bed table and not on the barrier. LPN #1	F 880	were present. The corrective actions for Resident #39 were for the DON to in-service Licensed Practical Nurse (LPN) #1 on our Infection Control Policies including Cross-Contamination and observe LPN #1 during Med Pass to ensure understanding and compliance. This occurred on 9-16-2019. The corrective actions for Resident #18 were for the DON to in-service Registered Nurse (RN) #1 on our Infection Control Policies including Handwashing/Hand Hygiene and Dressing, Dry/Clean and to observe RN#1 during wound care to ensure understanding and compliance. This occurred on 9-19-2019 All residents receiving injectable insulin have the potential to be affected. All residents receiving wound care/ dressing changes have a potential to be affected. To ensure that these deficient practices do not recur the DON/Infection Prevention Nurse will in-service all nurses on infection control policies including Cross-Contamination, Handwashing/Hand Hygiene and Dressing, Dry/Clean. This occurred on 09-10-2019, 09-11-2019, 09-17-2019, 09-18-2019 and 09-25-2019. The DON/Infection Prevention Nurse will observe insulin administration and wound care weekly for four(4) weeks and then monthly for three(3) months starting on 09-26-2019. The results will be reported to the Quality Assurance and Assessment (QAA) committee and evaluated for effectiveness and changes will be made	

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F 880	Continued From page 9 wiped the right abdomen with an alcohol prep and then injected the 15 units of Insulin into the abdomen. LPN #1, still wearing the gloves, picked up the trash, then picked up the multi-dose Insulin bottle and placed it in her right pocket. LPN #1 removed her gloves and washed her hands in Resident #39's bathroom. When asked where she put the Insulin after she picked it up, LPN #1 stated "It's in my pocket" and she reached in her pocket, pulled the insulin out of her pocket, held the insulin up, and then placed it back into her pocket. LPN #1 exited the room and placed the multi-doe Insulin bottle back into the medication cart. LPN #1 locked the cart and walked away from the cart. During an interview, on 09/03/19 at 11:35 AM, LPN #1 was asked if she took the bottle that was in her pocket and placed it back into the medication cart without cleaning it. LPN #1 stated "yes I put it back in the medication cart". When LPN #1 was asked if the bottle that she had placed back into the medication cart and that she had was the same multi-dose insulin bottle that she had taken into Resident #39's room, LPN #1 stated "yes, it sure is". An interview on 09/04/19 02:50 PM, with LPN #1 revealed, "I did sit the insulin off of the barrier. I wiped the table with a bleach wipe but I did sit the insulin off of the barrier. I did put the bottle of Insulin in my pocket and I did take it from my pocket and place it back into the medication cart. It is a cross contamination issue with me placing it back in the cart without cleaning the bottle." A review of the facility document titled "Bedford Care Orientation" dated 1/4/17, revealed LPN #1 was orientated to Infection Control Policies	F 880	as recommended by the QAA committee. The corrective actions will be completed by 9-27-2019.	

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F 880	Continued From page 10 9/18/18. An interview on 09/04/19 at 3:13 PM, with the Director of Nursing (DON), revealed, "It is a cross- contamination issue and an infection control issue with LPN #1 placing the insulin in her pocket and then placing it back in the medication cart without cleaning it first". Resident #18 Review of the Policy and Procedure of "Handwashing/Hand Hygiene", Policy Statement: This facility considers hand hygiene the primary means to prevent spread of infections. The Policy and Procedure of "Dressings, Dry/Clean", Policy revealed the following: Wash and dry your hands thoroughly. Put on clean gloves. Loosen tape and remove soiled dressing. Wash and dry your hands thoroughly. Put on clean gloves." On 09/04/19 at 2:22 PM, observation revealed Registered Nurse (RN) #1 performed wound care on resident #18's thoracic area, RN #1 did not wash her hands. RN #1 applied clean gloves, removed the old dressing, removed dirty gloves, and applied the dirty dressing in the dirty gloves. RN #1 did not wash her hands; she applied clean gloves, cleansed the wound, patted the wound dry, applied the nickel layer of Santyl, and covered with the wound with a Tegaderm Foam Dressing. During an interview on 09/05/19 at 10:16 AM, RN #1 confirmed she failed to wash her hands and change her gloves, before the wound care, and during treatment of the wound. On 09/05/19 at 10:37 AM, the Director of Nursing stated she would have to review the policy to determine the procedure, since it's been so long	F 880		

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F 880	Continued From page 11 since she has performed wound care. ,	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PICAYUNE	**2797 COOPER ROAD** **PICAYUNE, MS 39466**

(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
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 | 09/20/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255343	A. BUILDING _____ B. WING _____	09/04/2019

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E 000	Initial Comments ********** Survey conducted on 09/04/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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