STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255150	A. BUILDING _____ B. WING _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MENDENH	925 WEST MANGUM AVENUE MENDENHALL, MS 39114

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 09/05/2023 through 09/07/2023. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F-558, F-565, F-574, F-583, F-693, F-695, F-732, F-761, F-880, F-883, and F-887. The facility had a census of 53 and was licensed for 60 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review, the facility failed to keep the call light within the resident's reach for two (2) of three (3) observations. Resident #8. Findings include: Review of the facility's policy titled, "Call Lights: Accessibility and Timely Response," with revised date of 08/02/22, revealed, "Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized	F 558	1. The call light for Resident #8 was placed within easy reach on 9-7-2023 by the Certified Nursing Assistance (CNA). 2. All Residents have the potential to be affected by the deficient practice. 3. All nursing staff were in-serviced on the facility's call light accessibility policy by the Staff Development Nurse beginning on 9-18-2023 and was completed by 9-19-2023.	10/12/23

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

Electronically Signed | 09/26/2023

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F 558	Continued From page 1 location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 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 09/05/23 at 01:43 PM, an observation of Resident #8 revealed the resident was lying in bed with the head of the bed elevated. The resident's call light was lying on the floor. On 09/05/23 at 02:44 PM, an observation revealed a Certified Nursing Assistant (CNA) in Resident #8's room, having a conversation with the resident. Upon entry into the resident's room after the CNA left, revealed the call light remained on the floor. On 09/05/23 at 02:46 PM, an observation and interview with Resident's #8 in his room revealed his call light was located on the floor and not within his reach. Housekeeper #1 entered the resident's room, saw that the call light was not within reach of the resident and picked it up and placed next to the resident. On 09/05/23 at 03:19 PM, in an interview with Housekeeper #1, she revealed that the call light is the responsibility of all employees. She confirmed that it was found on the floor and that it should have been within the residents' reach. The housekeeper revealed that due to the resident's limitations, his call light should be available to him at all times. On 09/05/23 at 4:18 PM, Resident # 8 was observed lying in his bed with his eyes closed.	F 558	4. Registered Nurse Supervisor(s), beginning 9-9-2023, will make rounds to every resident room, two times times daily for one week, then three times per week for twelve weeks. These rounds will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting for three months beginning 9-29-2023 to ensure sustained compliance.	

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F 558	Continued From page 2 The resident's call light was laying on top of his bedside table on the left side of his bed. Resident #8 demonstrated he was able to reach his call light. Resident # 8 stated he could reach it today, but states when he can't reach it, he just yells for assistance. On 09/06/23 at 09:23 AM, during an interview, the Director of Nurses (DON) revealed that call lights are the responsibility of all employees, but especially nursing staff because it's the warning system to alert them of something being wrong. The DON revealed the call light system is a part of resident care and is a key to quick response. A record review of the "Admission Record" of Resident # 8 revealed the resident was admitted by the facility on 8/14/2020, with the diagnoses that included Dysphagia Following Cerebral Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Chronic Obstructive Pulmonary Disease, Unspecified and Obstructive Sleep Apnea. A record review of Resident # 8's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 06/19/2023, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 558		
F 565 SS=C	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F 565		10/12/23

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F 565	Continued From page 3 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to provide a private meeting space for the resident council members monthly meetings for six (6) of six (6) resident council meetings reviewed. Findings Include: Review of the facility's policy, "Resident Rights",	F 565	1. On 9-21-2023, the facility purchased a screen to cover the hall and cut off traffic when the group is meeting. 2. All Residents have the potential to be affected by the deficient practice. 3. All staff were in-serviced on 9-18-2023	

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F 565	Continued From page 4 revised 6/1/23, revealed, " ...Policy Explanation and Compliance Guidelines ...7. Privacy and confidentiality ...a. Personal privacy includes accommodations ...meeting of family and resident groups ..." During the resident council group meeting on 9/5/23 at 2:00 PM, the resident group stated they were not allowed privacy during the resident council meetings. The meetings were held in the resident and staff dining room, which was a common area, and the group complained that staff always interrupt the meeting. During the meeting, staff were observed coming in and out of the dining room, getting beverages, and bringing dirty trays to the kitchen. Staff were also sitting in the dining area on break during the resident group meeting. During an interview on 9/7/23 at 11:00 AM, with the Administrator, he confirmed that the residents did not have a private place to have resident council meetings. The Administrator said he had not thought about it and would figure out a way to close off the common area during the resident council meetings.	F 565	on the requirement that all staff honor the group's privacy. The inservice was provided by each department head and or the staff development nurse. The President of the Resident Council approved the plan to keep their meetings private on 9-18-2023 4. Monitoring of the process will be accomplished by observation beginning 9-9-2023 monthly, by the administrator, for three months to ensure compliance during the resident council meetings. Findings will be taken to the monthly Quality Assessment and Assurance Committee for three months beginning 9-29-2023 to ensure sustained compliance.	
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this	F 574		10/12/23

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F 574	Continued From page 5 section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 574		

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F 574	Continued From page 6 (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and facility policy review the facility failed to provide contact information for filing grievances or complaints concerning any suspected violation of the State or Federal nursing facility regulations for three (3) of three (3) days of survey. Findings Include: Review of the facility's policy, "Resident Rights", revised 6/1/23, revealed, "The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility ...Policy Explanation and Compliance Guidelines ...8. A posting of names, addresses and phone numbers of all pertinent state client advocacy groups will be available in the facility... Information and communication ...g.	F 574	1. Resident's rights are prominently displayed in the lobby on the wall and it is part of the admissions packet. Resident rights were distributed on the August 4, 2023 Resident Council meeting and was captured in the minutes. Additional copies were distributed to all residents on 9-20-2023 and are given to residents and or family members on admission. The State Health Department Hot Line number was posted on 9-6-2023 by the administrator. The Hot Line number is located adjacent to the Ombudsman poster in a prominent area in the facility and visible to all residents, family members, visitors and staff. 2. All Residents have the potential to be affected by the deficient practice.	

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F 574	Continued From page 7 Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, noncompliance with the advance directive's requirements and requests for information regarding returning to the community ..." During observations on 9/5/23 at 10:30 AM, 9/6/23 at 12:30 PM, and 9/7/23 at 9:00 AM, there was no information posted regarding filing grievances or complaints with the State Agency (SA). During the resident council group meeting on 9/5/23 at 2:00 PM, the residents stated that they did not know where the information was posted in the building regarding contact information for the SA regarding complaints or grievances. The residents said they have made complaints to the Dietary Manager, Administrator and Director of Nursing (DON) regarding dietary services and medication administration, but they were not aware that they could contact the SA for their if they felt nothing was being done about their grievances. During an interview on 9/7/23 at 11:00 AM, with the Administrator, he confirmed the State Agency hot line number was not posted in the facility. He stated he had been hired during the COVID-19 pandemic and was not aware that the required information was not posted and available to the residents.	F 574	3. In-service was performed by the administrator to the supervisory staff on 9-29-2023 4. Beginning 9-9-2023, the administrator will make weekly audits to ensure that the State Health Department Hot Line Number continues to be prominently displayed for twelve weeks. The audits will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting for three months Beginning on 09-29-2023 to ensure sustained compliance.	
F 583 SS=D	Personal Privacy/Confidentiality of Records	F 583		10/12/23

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F 583	Continued From page 8 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to	F 583	1. The sign posted on resident # 23's personal refrigerator was removed during	

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F 583	Continued From page 9 ensure a dignified living environment for a resident who had signs regarding her care posted in view of visitors and other residents for one (1) of 15 sampled residents. Resident #23 Findings Include: Review of the facility's "Resident Rights," revised 6/1/23, revealed " ...7. Privacy and confidentiality. The resident has a right to ...confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care ..." On 09/05/23 at 2:49 PM, during an observation of Resident #23, there was a handwritten sign located on her personal refrigerator, within view of other residents and visitors, which indicated "Thickened Liquids". On 09/06/23 at 9:30 AM, during an observation of Resident #23, the sign indicating thickened liquids was observed on the resident's personal refrigerator in her room. On 9/7/23 at 10:00 AM, Resident #23 was observed in bed and there was a visitor at the Residents roommate's bedside. The sign regarding Thickened Liquids was posted in the view of the visitor. Record review of the "Admission Record" revealed the facility admitted Resident #23 to the facility on 2/6/23 with diagnoses that included Dementia. Record review of the Quarterly Minimum Data Set (MDS), dated 08/07/23, revealed Resident #23	F 583	the survey by the Director of Nursing (DON). This was done on 9-7-2023. 2. All Residents have the potential to be affected by the deficient practice. 3. All nursing staff was in-serviced on Privacy and Confidentiality and not posting information in resident's rooms by the Staff Development nurse on 9-26-2023. 4. The Registered Nurse Supervisor will use the Registered Nurse Supervisor Round Checklist to Audit ten rooms beginning 9-11-2023, three times per week for four weeks and one time a week for eight weeks to ensure that no signage with personal information is posted. These checklist will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee for three months beginning 9-29-2023 to ensure sustained compliance.	

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F 583	Continued From page 10 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated her cognition was moderately impaired. Record review of the "Order Summary Report" revealed Resident #23 had a Physician's Order, dated 06/15/2023, for "NAS (No Added Salt) diet Mechanical Soft texture, nectar consistency." During an interview on 09/07/23 at 8:50 AM, with the Director of Nursing (DON), she stated she did not know there were signs posted in resident rooms with medical information related to the resident. She said they do not post signs because of Health Insurance Portability and Accountability Act (HIPPA) and the resident may not want everybody to know what kind of care they are getting.	F 583		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and	F 693		10/12/23

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F 693	Continued From page 11 services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that tube placement was checked prior to flushing the enteral feeding tube with water for one (1) of (1) observations of enteral feedings. Resident #9 Findings include: Review of the policy, "Administering Medications through an Enteral Tube," with a revision date of 8/2/22, revealed, " ...19. For nasogastric (NG) and gastrostomy (G) tubes, check placement: ...a. Observer for a change in the external tube length. b. Observe for signs of respiratory distress. C. Auscultate the abdomen, but do not rely on this as the singular method to differentiate between respiratory, gastric, esophageal and bowel placement: (1) Attach 60 mL (milliliter) syringe containing approximately 10 cc (cubic centimeter) air. (2) Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing. (3) Listen for "whooshing" sounds to check placement of the tube in the stomach..." On 09/06/23 at 2:35 PM, observed Licensed Practical Nurse (LPN) #2 flushing the peg (percutaneous endoscopic gastrostomy) tube of Resident #9 with 200 ml of water. LPN #2 drew up 60 ml of water in the syringe and began to flush the peg tube. She continued until she had	F 693	1. Licensed Practical Nurse (LPN) # 2 was in-serviced on 9-8-2023 by the Registered Nurse Supervisor on the facility's procedure for verifying the feeding tube placement prior to giving flushes or administering medications. 2. All Residents with feeding tubes have the potential to be affected by the deficient practice. 3. All licensed nursing staff were in-serviced on 9-26-2023 by the Staff Development Nurse on the facility's procedure for verifying placement of feeding tube policy. Each nurse was observed on 9-26-203, by the Staff Development Nurse, performing the procedure and a skills checklist was completed. Findings were reviewed with each nurse and corrections were provided if needed. 4. The Registered Nurse Supervisor will monitor by observation during feeding tube procedures once per week for twelve weeks beginning 9-11-2023. The skills checklist will be reviewed by the Quality Assessment and Assurance Committee for three months begining on 9-29-2023 to ensure	

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flushed the tube with 200 ml. LPN #2 did not check placement prior to flushing.

On 09/06/23 at 2:50 PM, during an interview, LPN #2 confirmed she forgot to check placement prior to flushing. She stated she should have checked to make sure it was still in place, as it could have been dislodged and caused complications like aspiration pneumonia or sepsis if the fluid went into the abdominal cavity.

On 09/06/23 at 5:00 PM, in an interview with Registered Nurse (RN) #1/ Charge Nurse, she stated nurses should always check placement prior to flushing peg tubes with water. She stated nurses could cause organ damage by not checking placement.

On 09/06/23 at 5:27 PM, in an interview with Director of Nursing (DON), she confirmed that LPN #2 should have checked placement before flushing the peg tube. She stated if a peg tube is not in place, it could cause resident pain and rupture an organ. She stated she expects nurses to always check placement before flushing or feeding.

A record review of the "Admission Record" of Resident #9 revealed an admit date of 4/19/22, with diagnoses that include Chronic Obstructive Pulmonary Disease, Essential Hypertension, and Schizophrenia.

Record review of the "Order Summary Report," with active orders as of 9/7/23, revealed an order dated 6/23/2023 "Enteral Feed Order: ... Flush with 200 ml of water qid (Four times a day)."

A record review of Resident #9's Quarterly

sustained compliance.

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F 693	Continued From page 13 Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 7/31/23 revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure cautionary signage was posted related to oxygen usage for one (1) of one (1) resident reviewed for respiratory conditions. Resident #8 Findings Include: Review of the facility's policy, "Oxygen Administration," with revised date of 08/02/22, revealed, "Purpose ...The purpose of this procedure is to provide guidelines for safe oxygen use ... Equipment and Supplies...The following equipment ...will be necessary when performing this procedure ...4. "No Smoking/Oxygen in Use" signs ... Steps in the Procedure... 2. Place an "Oxygen in Use" sign on the outside of the room entrance door. Close the door ..."	F 695	1. "No Smoking/Oxygen in Use" signs were posted outside of Resident #8's room on 9-8-2023 by the registered nurse supervisor. 2. All Residents have the potential to be affected by the deficient practice. 3. All staff were in-serviced on cautionary signage was completed on 9-26-2023 by the Staff Development Nurse and the administrator. 4. The Registered Nurse Supervisor will use the Registered Nurse Supervisor Checklist to audit ten rooms three times per week for four weeks beginning on 9-11-2023, and then once per week for	10/12/23

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F 695	Continued From page 14 On 09/05/23 at 11:21 AM, an initial observation of Resident # 8, revealed the resident was receiving oxygen by way of nasal cannula using an oxygen concentrator. There was no cautionary signage on the door of the room, indicating that oxygen was being administered. Observation on 09/05/23 at 01:43 PM, revealed Resident #8, was lying in bed with the head of bed elevated and receiving oxygen by way of oxygen concentrator per nasal canula. There continued to be no cautionary signage on the door of the room, indicating that oxygen was being administered. A record review of the "Admission Record" of Resident # 8 revealed the resident was admitted by the facility on 8/14/2020, with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Chronic Obstructive Pulmonary Disease and Unspecified and Obstructive Sleep Apnea. Record review of the "Physician's Order Sheet," revealed a Physician's Order dated 06/07/23, for "Oxygen at 2L (liters) prn (as needed) N/C (nasal cannula) r/t (related to) shortness of breath." On 09/06/23 at 12:20 PM, in an interview with the Director of Nursing (DON), she stated it was her expectation that all residents receiving oxygen therapy have cautionary signage on the doors for safety. On 09/07/23 at 12:15 PM, in an interview and observation with Licensed Practical Nurse (LPN) #2, she confirmed there was an O2 Concentrator in the room for Resident #8. She also confirmed that there were no cautionary signs on the door	F 695	twelve weeks to ensure that cautionary signage is posted where oxygen is in use. These checklist will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting for three months beginning 9-29-2023 to ensure sustained compliance.	

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F 695	Continued From page 15 indicating the use of oxygen.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		10/12/23

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F 732	Continued From page 16 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure staffing information was posted in a prominent place readily accessible to resident and visitors for three (3) of three (3) survey days, having the potential to affect all residents residing at the facility. Findings include: Review of the facility's policy, "Posting Direct Care Daily Staffing Numbers," with revised date 07/21/22, revealed "Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents ... 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and LVNs (Licensed Vocational Nurses) and the number of the unlicensed nursing personnel (CNAs) (Certified Nurse Aides) directly responsible for the resident care will be posted in a prominent location (assessable to residents and visitors) and in a clean and readable format ... 5. Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care from. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator. Shift Supervisor will sign as form is completed ..." On 09/05/23 at 2:00 PM, an observation revealed	F 732	1. Nurse staffing information was posted at the entrance of the facility beginning 9-8-2023 by the Director of Nursing (DON). 2. All Residents have the potential to be affected by the deficient practice. 3. Registered Nurse Supervisors were in-serviced on 9-18-2023 and 9-19-2023 by the Staff Development Nurse on the requirement that nursing staff directly responsible for resident care form be posted daily in a prominent area. 4. Nursing staff information will be posted daily at the front entrance, at the beginning of each shift by the Registered Nurse Supervisor 9-9-2023. The nurse staffing information posted will be audited three times per week for four weeks and then once per week for eight weeks by the Director of Nursing. These audits will be reviewed by the Quality Assessment and Assurance Committee for three months beginning 9-29-2023 to ensure sustained compliance.	

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there was no posting of staffing noted throughout the building.

On 09/05/23 at 3:00 PM, during an interview with Office Worker #1, she explained staffing is located behind the nurses' station in a book and if someone needed to know the staffing, they could ask the staff at the desk.

On 09/06/23 at 09:45 AM, an observation revealed there was no posting of staffing noted throughout the building.

On 09/06/23 at 10:30 AM, during an interview with LPN #2, she explained she does not know anything about where staffing is posted in the building.

On 09/07/23 at 11:00 AM, during an interview and observation with RN #2, she explained she knew nothing about posting of staffing and confirmed there was no posting of staffing that could be seen.

On 09/07/23 at 11:15 AM, during an interview with the Director of Nursing (DON), she confirmed staffing has not been posted and she is not sure how long it has not been posted. She is aware that daily staffing is required to be posted and staffing used to be posted by the Staff Developer but since the change in staff, she was not aware it was not being posted. She explained the posting of daily staffing should be her responsibility.

On 09/07/23 at 01:00 PM, during an interview with the Administrator, he explained he is aware the direct care daily staffing numbers should be posted daily for staff, visitors, and residents to

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F 732	Continued From page 18 see. He revealed he is not exactly sure who is responsible for posting the staffing, however, he will follow-up and see that daily staffing is posted.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to discard expired medications and ensure that opened multi-dose vials were dated when opened for two (2) of two (2) medication carts reviewed for medication	F 761	1. The identified medication was removed from the medicine cart and discarded properly and the medication was re-ordered on 9-8-2023 by the Registered Nurse (RN) Supervisor.	10/12/23

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F 761	Continued From page 19 storage. Findings include: Review of the policy, "Administering Medications," with a revision date of 8/2/22, revealed, "Medications shall be administered in a safe and timely manner, and as prescribed ... 12. The expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container ..." On 09/05/23 at 3:50 PM, a check of medication cart #1 with Licensed Practical Nurse (LPN) #1 revealed a 60-tablet bottle of sugar and starch free Magnesium Chloride with an expiration date of 9/30/22, a 100-tablet bottle of B complex vitamins with an expiration date of 12/22, an opened vial of Humulin R insulin without an open date on the vail and a vial of Lispro Insulin opened without an open date on the vail. LPN#1 stated she doesn't have time to check everything on the cart, every day. She revealed that she checks the expiration date prior to administering the medication, and if it were expired or if the insulin was not dated, she would not administer the medication. She stated that she would discard the medication and get a new bottle out of the medication room. LPN #1 explained that insulin can be given for 28 days after the vial is opened and after that, it is considered expired and should be discarded. LPN #1 confirmed that expired medications may not be as effective, causing residents to not receive the therapeutic effect desired from the medication. On 09/05/23 at 4:55 PM, a check of medication cart #2 with LPN #3 revealed Novolog Solution	F 761	Proper dates were placed on the new medication vial. 2. All Residents receiving insulin have the potential to be affected by the deficient practice. 3. All licensed nursing staff were in-serviced on 9-18-2023 and 9-19-2023, by the staff development nurse on looking for expired medication(s) or non-dated multiuse vials as well as properly dating multiuse vials when opening them. 4. The Registered Nurse Resident Care Coordinator, beginning 9-9-2023, will complete the pharmacy inspection form three times per week for two weeks and then weekly for ten weeks to ensure compliance with dating insulin vials when opened and expired medications are removed properly. The Pharmacy Inspection forms will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee for three months beginning on 9-29-2023 to ensure sustained compliance.	

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100 unit/ml open without an open date on the vial. She stated insulin from opened, undated vials should have not be given, as insulin is only considered effective for 28 days once the vial is opened. LPN #1 explained that nurses should checks the expiration dates of medications prior to administration and replace any medications that are outdated. LPN #1 confirmed that it is the responsibility of the nursing staff to check their carts for expired medication and replace as needed but admitted that she had not checked her cart today.

On 09/06/23 at 5:08 PM, in an interview with Registered Nurse (RN) #1/Charge Nurse, she stated nurses should discard all expired medications when they expire, as some expired medications can become toxic after the expiration date and others will not prove the therapeutic effect desired. The RN confirmed that insulins should be dated when opened and discarded after 28 days. The RN added that with so many over-the-counter medications being used, the best practice is for the nurse to check the expiration date prior to administering the medication to a resident.

On 09/06/23 at 5:35 PM, in an interview with the Director of Nursing (DON), she confirmed expired medications should not be in medication cart. She stated the nurse should check the over-the-counter medications kept in the medication carts weekly for expired dates and replace them with new bottles available in the medication room. She further explained that when insulin vials are opened, the nurses are supposed to date the bottles and discard the unused insulin after 28 days, as the residents may not receive the desired therapeutic effect after 28 days. The

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F 761	Continued From page 21 DON also confirmed that nurses should not administer insulin from an undated vial, as without knowing the date the vial was opened, there is no way to know whether it has been opened more than 28 days.	F 761		
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;	F 880		10/12/23

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F 880	Continued From page 22 (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 observation, interview, record review, and facility policy review, the facility failed to ensure infection control measures were consistently implemented to prevent the possible	F 880	1. Licensed Practical Nurse (LPN) # 1 was in-serviced by the Staff Development nurse on 9-6-2023 regarding the facility's infection control policies	

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(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 880	Continued From page 23 spread of infection when a nurse dispensed medication into her bare hands during the administration of medications for two (2) of nine (9) residents observed for medication administration. Residents #10 and #41. Findings include: Review of the facility's policy, "Infection Prevention and Control Program," with a revision date of 6/15/23, revealed "This facility has established and maintains 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 as per accepted national standards and guidelines ..." Resident #41 On 09/06/23 at 11:50 AM, an observation of Licensed Practical Nurse (LPN) #1 preparing medications to be administered to Resident #41, revealed the LPN dispensed four (4) pills out of the medication card into her bare hands and then placed them into the medication cup. The oral medications dispensed into her hand were Furosemide 40 mg (milligrams), Amiodarone HCL 200 mg, Gabapentin 100 mg, and Extended-Release Potassium Chloride 20 meq (milliequivalent). Prior to preparing the medications for administration to Resident #41, LPN #1 touched cart keys, the cart drawers, and the computer numerous times before dispensing the medication into her bare hands and placing them into the medication cup. After placing the medications into the medication cup, LPN #1 administered medications to Resident #41.	F 880	regarding medication administration. Resident #41 and Resident #10 were assessed for adverse reactions by the Registered Nurse Supervisor with none noted. 2. All Residents have the potential to be affected by the deficient practice. 3. All licensed nursing staff were in-serviced on 9-18-2023 by the Staff Development Nurse on infection control during the medication pass to include hand hygiene. Monitoring of the staff by the Staff Development Nurse began on 9-9-2023. The facility will comply with the Directed Plan of Correction (DPOC). A root cause analysis was performed on 9-28-2023, with the assistance of the Infection Preventionist and the Quality Assessment and Assurance Committee and the Governing Body. All staff will complete the Center for Disease and Control Prevention (CDC) module 7 Hand Hygiene course by 10-2-2023. The staff Development Nurse and Director of Nursing will ensure that hand hygiene skill competencies are completed by 10-2-2023 4. The Staff Development Nurse will complete medication administration observations beginning 9-11-2023 for two nurses per week for four weeks and then one nurse per week for eight weeks. The observations will be monitored and reviewed in the monthly	

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F 880	Continued From page 24 Resident #10 On 09/06/23 at 1:05 PM, an observation of LPN #1 preparing medications to be administered to Resident #10, revealed LPN #1 dispensed eight (8) pills out of the medication card into her bare hands and placed them into the medication cup. The oral medications dispensed into her hand were Carvedilol 6.25 mg, Clopidogrel Bisulfate 75 mg, Hydrochlorothiazide 25 mg, Loratadine 10 mg, Extended-Release Potassium Chloride 20 meq, Risperidone 1 mg, Rosuvastatin Calcium 20 mg, and Sertraline 100 mg. Prior to preparing the medications for administration to Resident #10, LPN #1 touched the medication cart keys, the medication cart drawers, and the computer numerous times prior to dispensing the medications into her bare hands and placing them into the medication cup. After placing medication into the medication cup, LPN #1 administered the medications to Resident #10. On 09/06/23 at 2:58 PM, in an interview with LPN #1, she revealed she should not have touched the medications with her bare hands, as that contaminated the resident's medications. LPN #1 explained that she knew better, but just forgot. LPN #1 confirmed that by putting the mediation in her hand, she could cause the spread of infection. On 09/06/23 at 5:30 PM, in an interview with the Director of Nurses (DON), she stated nurses should never put pills into their bare hands. She explained that nurses should dispense pills directly into the medication cup. The DON confirmed that the actions of LPN #1 is an infection control issue and could cause the spread of infection to the residents receiving the medications.	F 880	Quality Assessment and Assurance Committee meeting for three months beginning on 9-29-2023 to ensure sustained compliance.	

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F 880	Continued From page 25 A record review of the "Admission Record" of Resident #10, revealed the facility admitted the resident on 7/21/23, with diagnoses that included Type 2 Diabetes Mellitus, Essential Hypertension, and Anxiety Disorder. A record review of the "Admission Record" of Resident #41, revealed the facility admitted the resident to the facility on 7/1/22, with diagnoses that included Chronic Destructive Pulmonary Disease, Paroxysmal Atrial Fibrillation, and Congestive Heart Failure.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		10/12/23

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F 883	Continued From page 26 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility the facility failed to provide influenza and/or pneumococcal vaccinations as requested per their signed consents for four (4) of 21 sampled residents. Resident #16, #46, #47 and #51.	F 883	1. Resident #16, Resident #46, and Resident # 47 are scheduled to receive their influenza vaccination on October 2, 2023. The reason for the delay is that the vaccination for those over the age of sixty five was back-ordered. Resident #51	

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F 883	Continued From page 27 Findings include: A record review of the facility's policy, "Infection Prevention and Control Program," with revised date 06/15/23 revealed, "This facility has established and maintains 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 as per acceptable national standards and guidelines ... 7. Influenza and Pneumococcal Immunization: a. Resident will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. b. Residents will be offered the pneumococcal vaccines recommended by the CDC (Center for Disease Control) upon admission, unless contraindicated or received the vaccines elsewhere ..." Resident #16 A record review of Resident #16's "Admission Record" revealed the facility admitted the resident on 11/20/2020, with the diagnoses that included Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Acute Respiratory Failure with Hypoxia, and Type 2 Diabetes Mellitus Without Complications. A record review of Resident #16's "Order Summary Report," with active orders as of 09/07/2023, revealed an order for "Annual Flu vaccine unless contraindicated." A record review of Resident #16's "Clinical-Immunizations Record" revealed " ... Influenza Vaccine Regular Dose date given	F 883	received the Pneumococcal vaccination on 9-25-2023. 2. All Residents have the potential to be affected by the deficient practice. 3. When a resident, or resident representative, gives consent for a vaccination, the vaccination consented for will be entered into Point Click Care immunization tab for the resident as "consented" by the Registered Nurse Resident Care Coordinator, this process was began 9-21-2023. The consented list will be pulled from Point Click Care once a week by the Registered Nurse Care Coordinator and those vaccines will be administered by the Registered Nurse Care Coordinator or the Registered Nurse Supervisor. A root cause analysis was performed on 9-28-2023, with the assistance of the Infection Preventionist and the Quality Assessment and Assurance Committee and Governing Body. The facility will comply with the Directed Plan of Correction (DPOC). 4. The Director of Nursing will audit the immunizations weekly beginning 9-11-2023 for four weeks to varify compliance. Results of the audits will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting for three months beginning 9-29-2023 to ensure sustained compliance.	

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F 883	Continued From page 28 11/23/2020 ..." A record review of Resident #16's "Influenza Vaccination Informed Consent," with revised date September 2015, revealed resident's Representative checked and signed on 11/18/20 " ... Influenza vaccination annually, in the fall (October 1st through March 31st or as soon as vaccine is available) ..." Resident #46 A record review of Resident #46's "Admission Record," revealed the facility admitted the resident on 02/01/2022, with the diagnoses that included Chronic Atrial Fibrillation, Unspecified, Essential (Primary) Hypertension, and Nonrheumatic Mitral (Valve) Insufficiency. A record review of Resident #46's "Order Summary Report," with active orders as of 09/07/2023, revealed an order for "Annual Flu vaccine unless contraindicated." A record review of Resident #46's "Influenza Vaccination Informed Consent" with revised date September 2015, revealed the Resident's Representative checked and signed on 01/28/2022 " ... Influenza vaccination annually, in the fall (October 1st through March 31st or as soon as vaccine is available) ..." A record review of Resident #46's "Clinical-Immunizations Record" revealed " ...Influenza Vaccine High Dose Consent Required ... Influenza Vaccine High Dose Consent Refused ..." Resident #47	F 883		

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A record review of Resident #47's "Admission Record" revealed the facility admitted resident on 03/04/2023 with the diagnoses of Hypokalemia and Type 2 Diabetes Mellitus.

A record review of Resident #47's "Order Summary Report" with active orders as of 09/07/2023 revealed an order for annual Flu vaccine unless contraindicated.

A record review of Resident #47's "Influenza Vaccination Informed Consent" with revised date September 2015 revealed resident checked and sign on 03/04/2022 " ... Influenza vaccination annually, in the fall (October 1st through March 31st or as soon as vaccine is available) ..."

A record review of Resident #47's Annual "Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 08/21/2023, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.

A record review of Resident #47's "Clinical-Immunizations Record" revealed " ... Influenza Vaccine High Dose Refused and Influenza Vaccine High Dose 03/04/2022 Historical ..."

Resident #51
A record review of Resident #51's "Admission Record," revealed the facility admitted resident on 04/21/2023, with diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Paroxysmal Atrial Fibrillation, and Anemia.

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A record review of Resident #51's "Pneumococcal Vaccination Informed Consent," dated 09/26/2022, revealed the resident and the Resident's Representative, checked and e-signed on 04/21/2023 " ...I have NOT received a pneumococcal vaccination in the past five years. I GIVE the facility permission to administer a pneumococcal vaccine unless medically contraindicated ..."

A record review of Resident #51's "Quarterly MDS with an ARD of 07/31/2023, revealed a BIMS score of 13, which indicated the resident was cognitively intact.

On 09/07/23 at 12:40 PM, during an interview with Resident #46, he explained he doesn't remember receiving a flu vaccine last year. During this time, in an interview with Resident #47, who is the wife of resident #46's, she explained she thought she had signed for the Flu vaccines on admission for both her and her husband but doesn't remember receiving the vaccines last year. Resident #47 revealed if she signed for the immunizations, then then nursing staff should have given them. She reported she had always taken a Flu vaccine every year prior to coming into the facility and does not remember ever refusing to receive a Flu vaccine.

On 09/07/23 at 01:00 PM, during an interview with Resident #51, he explained he was admitted in April of this year and confirmed he had signed a consent for the Pneumococcal vaccine, but he has not yet received it. Resident #51 stated he would still like to receive the vaccine.

On 09/07/23 at 01:30 PM, during an interview with Nurse Practitioner, she explained Resident

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#51 has chronic diseases and he would benefit from receiving a Pneumococcal vaccine and if resident had given consent for the vaccine, she would expect the nursing staff to administer the vaccine within days of signing the consent and would not expect the resident to wait for months for any vaccine. The Nurse Practitioner further explained, if a resident or representative gave consent for annual influenza vaccines, she would expect nursing staff to administer the vaccine and keep a record of the consent and administration.

On 09/07/23 at 02:20 PM, during an interview with the Infection Preventionist (IP), she confirmed the Influenza and Pneumococcal consent forms used by the facility, was a consent that gave consent for annual vaccinations. She confirmed Residents #16, 46, and 47 did marked and signed the consent to receive the annual Influenza vaccine, however, she reported that resident #46 and 47 refused the 2022 Influenza vaccinations. The IP did not have a signed refusal and did not know she needed a consent for refusal and had only documented the refusal in the immunization record. The IP confirmed Resident #51 had signed for the pneumococcal vaccine, and she had just missed the vaccine in error.

On 09/07/23 at 02:30 PM, during an interview with DON, she confirmed the vaccine consents signed for annual influenza vaccines gives permission to go ahead and give the vaccine annual unless the resident refused, and a new consent must be signed for refusal and kept in the medical record. She reviewed the records and confirmed all residents had signed consents for the vaccines and no vaccines were given.

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F 883	Continued From page 32 On 09/07/23 at 02:45 PM, during an interview with the Administrator, he explained he expects nursing staff to carry out nursing duties and to follow residents' or representatives wishes for vaccines as consented.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 887		10/12/23

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F 887	Continued From page 33 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to administer the COVID-19 vaccine as requested and consented for one (1) of 21 residents reviewed for COVID-19 vaccinations. Resident #51. Findings include: A record review of the facility's policy "COVID-19 Vaccination," with revised date 06/15/2023 revealed, "It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complication from COVID-19 (SARS-CoV-2) by	F 887	1. New consent forms were mailed out for Resident #51 on 9-21-2023 for the new vaccination. We are currently working with Local Medical Clinic or administered by staff to deliver the vaccine as soon as it is available. 2. All Residents have the potential to be affected by the deficient practice. 3. When a resident, or resident representative, gives consent for a	

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F 887	Continued From page 34 educating and offering our residents and staff the COVID-19 vaccine ..." A record review of the facility's policy "Infection Prevention and Control Program," with revised date 06/15/23 revealed "This facility has established and maintains 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 as per acceptable national standards and guidelines ...8. COVID-19 Immunization: a. Residents and staff will be offered the COVID-19 vaccine ... d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance. e. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine." A record review of Resident #51's "Clinical-Immunizations Record" revealed " ... SARS-COV-2 (COVID-19) (Dose 1) Immunization Req. (Requested)." and review of the "Clinical -Immunizations revealed, ...Consent Confirmed Date: 06/08/2023 ..." A record review of the facility's "COVID-19 Vaccination Roster," revealed Resident #51 requested to be vaccinated. On 09/06/23 at 02:10 PM, during an interview with the Director of Nursing (DON), she explained the Infection Preventionist (IP) nurse is the staff member who oversees the immunization program and administer the vaccines. The DON noted that (Name of Pharmacy) used to do a COVID-19	F 887	vaccination, the vaccination consented for will be entered into Point Click Care immunization tab for the resident as "consented" by the Registered Nurse Resident Care Coordinator, this process was began 9-21-2023. The consented list will be pulled from Point Click Care once a week by the Registered Nurse Care Coordinator and those vaccines will be administered by the Registered Nurse Care Coordinator or the Registered Nurse Supervisor. A root cause analysis was performed on 9-28-2023, with the assistance of the Infection Preventionist and the Quality Assessment and Assurance Committee. The facility will comply with the Directed Plan of Correction (DPOC). 4. The Director of Nursing will audit the immunizations weekly beginning 9-11-2023 for four weeks to verify compliance. Results of the audits will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting for three months beginning 9-29-2023 to ensure sustained compliance.	

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clinic and would come and give the vaccines but now that most everyone has been vaccinated, they no longer do the clinics. The DON revealed the facility does not keep COVID-19 vaccines on hand, however, the hospital next door has the vaccines, and all the facility must do is call the hospital and the COVID-19 vaccine will be delivered. The hospital will bring within days, and she expects anyone who wants the vaccine to be administered within days and should never have to wait months.

On 09/07/23 at 01:00 PM, during an interview with Resident #51, he explained he was admitted in April and confirmed he did sign a consent for the COVID-19 vaccine, and he has not yet received it. He reported he still would like the vaccine, especially now since the facility has COVID-19 in the facility.

On 09/07/23 at 01:30 PM, during an interview with Nurse Practitioner (NP), she explained Resident #51 does have chronic diseases and he would benefit from receiving COVID-19 vaccines. The NP revealed if a resident had given consent for the vaccine, she would expect then nursing staff to administer the vaccine within days and would not expect the resident to wait for months for any vaccine.

On 09/07/23 at 02:20 PM, during an interview with IP nurse, she explained Resident #51 had signed for the COVID-19 vaccine and she was waiting on a COVID-19 clinic for the COVID-19 vaccine, but there had not been any effort in scheduling a clinic.

On 09/07/23 at 02:45 PM, during an interview with the Administrator, he explained he expects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255150	A. BUILDING _____ B. WING _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MENDENH	925 WEST MANGUM AVENUE MENDENHALL, MS 39114

(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 887	Continued From page 36 nursing to carry out nursing duties and to follow residents' or representatives wishes for vaccines as consented. A record review of Resident #51's "Admission Record," revealed the facility admitted the resident on 04/21/2023, with diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Paroxysmal Atrial Fibrillation, and Anemia. A record review of Resident #51's Quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/31/2023, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact.	F 887		