STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255153	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEDFORD CARE CENTER OF NEWTON	**1009 SOUTH MAIN STREET NEWTON, MS 39345**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, staff interview, facility policy review, and record review, the facility failed to prevent the likelihood of the spread of COVID-19 as evidenced by the lack of social distancing and wearing masks by residents in the Alzheimer's unit for six (6) of six (6) tours of the unit and lack of social distancing and wearing masks by the staff for one (1) of one (1) tour of the employee dining room. Findings include: Review of the facility's Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures policy, dated April 2020, revealed it was the policy statement that this facility follows recommended standard and transmission-based precautions, environmental cleaning, and social distancing practices to prevent the transmission of COVID-19 within the facility. The Policy Interpretation and Implementation revealed: #1. This policy is based on current recommendations for standard precautions and transmission-based precautions, environmental cleaning, and social distancing for COVID-19. #8. Group outings, group activities, and communal dining are canceled until further notice. 9. Social distancing is enforced among residents. An interview, on 8/25/20 at 10:10 AM, with the Administrator, revealed the facility has had 12 COVID-19 positive residents and 18 COVID-19 positive employees. An observation, on 8/25/20 at 10:40 AM, revealed 16 residents was in the Alzheimer's unit sitting at tables in the dining area with one (1) to four (4) residents at each table. The residents were eating and drinking snacks and talking. They were not socially distanced and none were wearing masks. At no time did any of the three (3) staff members present attempt to distance the residents or apply masks. An interview, on 8/25/20 at 10:42 AM, with Licensed Practical Nurse (LPN) #1, confirmed the residents were not socially distanced. An observation, on 8/25/20 at 11:20 AM, revealed residents in the Alzheimer's unit sitting at the dining tables, not socially distanced and no masks on. The Social Service Director and two (2) Certified Nursing Assistants were present on the unit. An observation, on 8/25/20 at 11:40 AM, revealed lunch had been served on the Alzheimer's unit. The residents were still sitting at the tables eating and talking and not socially distanced. An observation and interview, on 8/25/20 at 12:00 PM, with LPN #1, confirmed the residents were not socially distanced. She stated that the residents at the tables were not as far apart as they should be. LPN #1 stated that they should be six (6) feet apart for safety reasons, in case one resident was sick, it would prevent others from getting sick easily. She stated they did try for a little while to socially distance the residents, but didn't know why they stopped. An observation and interview, on 8/25/20 at 12:45 PM, with Registered Nurse #1, the Infection Preventionist confirmed the residents in the Alzheimer's unit should not be sitting so close during the meal. She stated that there are two rooms on the unit, and they should try to split them up in the two (2) areas. She stated she thinks they may have tried at one time, but some of the residents were not compliant. She stated the residents not being six (6) feet apart was not good because, if they coughed or sneezed they are at risk to possibly spread germs to all of them. An observation, on 8/25/20 at 1:00 PM, with RN #1, the Infection Preventionist, revealed 14 employees in the front area of the dining room eating lunch and not socially distanced. The observation revealed two (2) to five (5) employees at each of the tables. Observation of the back dining area revealed four (4) employees eating lunch, two (2) were socially distanced at separate tables alone and two (2) were sitting together at a table not six (6) feet apart. An observation and interview, at 1:02 PM, in the presence of Registered Nurse (RN) #1 revealed Licensed Practical Nurse (LPN) #1, LPN #2, Certified Nursing Assistant (CNA) #1, CNA #2, and CNA #3 sitting together at a table with no masks on and not at least six (6) feet apart. During an interview with LPN #2, concerning social distancing, she held her arm up and out to her side and stated she thought they should be about that far apart, but when questioned she confirmed that would not be six (6) feet. LPN #1 and #2, CNA #1, CNA #2, and CNA #3 confirmed they had attended in-services that addressed being six feet apart to prevent the spread of COVID. An observation and interview, at 1:05 PM in the presence of RN #1, revealed Dietary Staff #1, Dietary Staff #2, and Dietary Staff #3 sitting at a dining table eating lunch and talking. Dietary Staff #1 stated that they usually go out to their cars to eat lunch, but didn't today because it was raining. Dietary staff #3 stated they keep their masks down when they are eating and put them back up when they finish eating and talk. Dietary Staff #1, #2, and #3 confirmed they had attended in-services on social distancing. An interview, on 8/25/20 at 1:10 PM, with the Administrator revealed that all staff had been in-serviced on social distancing. She stated they know five (5) people at the table is too many and that this could cause the spread of COVID. An observation and interview, on 8/25/20 at 1:15 PM, with the Director of Nursing (DON) revealed residents in the Alzheimer's unit at the dining tables not wearing masks or socially distancing. The DON stated they had attempted in the beginning to get the residents to stay in their rooms, wear masks, and socially distance, but it didn't work. The DON stated she guessed they were going to have to try something. An interview, on 8/25/20 at 1:20 PM, with LPN #1, revealed when COVID first started she thought they tried social distancing with the Alzheimer residents. She stated the only time she had seen any of those (Alzheimer) residents with a mask on was when they came out of the unit for something. During an observation and interview, on 8/26/20 at 1:26 PM, with the Nurse Practitioner, she confirmed the residents were not socially distanced. She stated it would be good if the staff tried to keep the residents six (6) feet apart. She stated the staff should follow CDC (Centers for Disease Control and Prevention) guidelines. Review of the facility's in-service sign-in sheets revealed LPN #1 and #2, CNA #1 and #3, and Dietary Staff #1, #2, and #3 had attended in-service education on COVID-19.

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

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.