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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>255149 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>03/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Bedford Care Center of Petal |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>908 S George Street<br>Petal, MS 39465 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37415</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents receiving oxygen (O2) therapy received care according to professional standards, as evidenced by, O2 tubing was undated for three (3) of four (4) days of survey. Resident #150</p> <p>Findings include:</p> <p>On 03/17/25 at 11:06 PM, an observation of Resident #150 revealed was receiving oxygen via nasal cannula at 3 liters per minute (LPM) for shortness of breath (SOB) every 24 hours as needed. The oxygen tubing was not labeled.</p> <p>On 03/18/25 at 1:16 PM, during a second observation of Resident #150 revealed the resident sitting up in a chair, receiving oxygen via nasal cannula at 3 LPM. The oxygen tubing was not labeled.</p> <p>On 03/19/25 at 2:19 PM, during a third observation and interview with Licensed Practical Nurse (LPN)#1 revealed Resident #150 was sitting up in a chair, receiving oxygen via nasal cannula at 3 LPM. The oxygen tubing was not labeled. LPN #1 reported the oxygen tubing and humidifier are changed every Sunday night and labeled with the date of change. However, she confirmed that the tubing in use at the time of this visit was not dated.</p> <p>During an interview on 03/19/25 at 2:30 PM, the Director of Nursing (DON) confirmed that facility practice requires oxygen tubing and humidifiers to be changed on Sunday nights and labeled with the date of change. She stated that this practice is in place to ensure compliance with protocols.</p> <p>A review of the Admission Record revealed the resident was admitted on [DATE] with diagnoses including Obstructive Sleep Apnea (Adult) (Pediatric) and Essential (Primary) Hypertension.</p> <p>A review of Order Audit Record revealed a physician order dated 3/18/25 O2 at 3L (liters) for SOB (shortness of breath).</p> <p>Record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact.</p> |

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