STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255153	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 Based on interviews, record review, and facility policy review, the facility failed to honor a resident's choice to receive visitors, as evidenced by, restricting visitation privileges in the dining room (a common area of the facility) with no reasonable clinical or safety explanation for one (1) of 15 sampled residents, with the potential to affect all residents who are served meals in the dining room. Resident #47 Findings include: Review of the facility's policy, Resident Right to Access and Visitation, revised 10/1/2022, revealed, .It is the policy of this facility to support and facilitate the resident's right to receive visitors of their choosing, at the time of their choosing .Visitation will be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life .Policy Explanation and Compliance Guidelines . 2 . Resident's family member are not subject to visiting hour limitation or other restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions .11. The facility will ensure all visitors enjoy full and equal visitation privileges, consistent with resident preferences . During an interview on 5/28/2024 at 10:30 AM, Resident #47's family member explained the facility would not allow her to visit the resident in the dining room. She stated she had been informed by the facility she could visit the resident in the resident's room or the family room, but not in the dining room. She said that not being able to eat with her family in the dining room was concerning and she had communicated with the Social Services Coordinator (SSC) but was told the only visitation options were the resident's room and the family room. During an interview on 5/29/24 at 10:54 AM, with the SSC, she confirmed that no one was allowed to visit residents in the dining room since the COVID-19 public health emergency. The facility continued to try to maintain distance between residents to reduce the spread of COVID-19. During an interview on 5/30/2021 at 10:30 AM, the Administrator stated that it was her decision to restrict visitation for residents to the family room or the resident's room. She explained that she was concerned about the spread of COVID-19, even though the facility was not in a COVID-19 outbreak. She said COVID-19 was still a concern in the community. She stated she had been informed that Resident #47's family member was concerned because she was unable to visit and eat with her family member in the dining room. (continued on next page)

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

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F 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Admission Record revealed the facility admitted Resident #47 on 3/22/23 with diagnoses including Muscle Wasting and Atrophy. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/28/24 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Surveyor: [NAME], [NAME] R. 50751

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 44179 Based on record review, staff interview, and facility policy review, the facility failed to ensure an advance directive, specifically a durable Power of Attorney (POA), was available and readily retrievable by facility staff for one (1) of 24 residents reviewed for advance directives. (Resident #29). Findings Include: A review of the facility's policy, Residents' Rights Regarding Treatment and Advanced Directives, revised 11/1/22, revealed, Policy: It is the policy of this facility to support and facilitate a resident's right to .formulate an advance directive. Definitions: Advance Directive is a written instruction, such as a . durable power of attorney for health care .Policy Explanation and Compliance Guidelines .3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart . A record review of the Clinical Resident Profile revealed the facility admitted Resident #29 on 5/2/2018 and she had current diagnoses including Alzheimer's Disease with Early Onset. Record review of the facility's document, Acknowledgement of Advance Directives Decisions, Rights, and Information, signed 5/1/2018, indicated Resident #29 had a POA. A record review of the electronic medical record (EMR) revealed there was no copy of a POA on the chart. On 5/28/24 at 1:57 PM, in an interview and record review with Registered Nurse (RN) #1/RN Supervisor, she explained if a resident had a POA, it would be scanned into the Misc tab of the EMR. RN #1 reviewed the EMR for Resident #29 and determined there was no POA in the chart. She confirmed there was no paper charts or any other area at the nurses station where a POA would be kept. RN #1 stated that Medical Records was responsible for scanning POAs into the EMR. On 5/28/24 at 2:00 PM, in an interview and record review with the Medical Records, she confirmed she was responsible for scanning in advance directives and POAs into the EMR. Upon review, she determined the POA was not in the EMR for Resident #29. She commented Resident #29 had lived at the facility for a long time and if the POA had not been scanned in, then it could be located either in the old medical records office or in the front office, which was locked after hours and on weekends. She confirmed the POA was not readily accessible to staff and stated, It just did not get scanned in. On 5/28/24 at 2:15 PM, Medical Records provided a copy of the POA for Resident #29 and stated it was found in the front office. On 5/29/24 at 4:05 PM, in an interview with the Director of Nursing (DON), she stated she was unaware Resident #29's POA was not readily accessible for review by facility staff and she expected all POAs to be scanned into the residents' EMR.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 41680 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident was free from the use of physical restraints, as evidenced by, an observation of a resident wearing a seat belt with no facility documentation of risk and benefits, physician order, consent, monitoring, assessments or medical symptoms for restraint use for one (1) of 15 sampled residents. (Resident #17) Findings include: Review of the facility's policy, Physical Restraint Application, revised 8/2/22, revealed, The purpose of this procedure is to provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints .Physical restraints are defined . as any manual method or physical or mechanical devise, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement .The resident must be physically and cognitively able to self-release devices such as .seat belts .If a resident cannot mentally and physically self-release, then the device is considered a restraint . On 05/28/24 at 11:40 AM, during an observation, Resident #17 was sitting in a wheelchair and had a seat belt that was attached to the chair and buckled in the front. His hands were contracted. He kept his hands positioned around his abdominal area. On 05/29/24 at 2:26 PM, in an observation an interview with Certified Nursing Assistant (CNA) #1, she stated Resident #17 was unable to use his hands and could not release the seat belt buckle without assistance. Resident #17 was sitting in his wheelchair with the seat belt device in place. CNA #1 asked Resident #17 to unbuckle his seat belt, but he said that he could not unbuckle it and asked the CNA to do it. Review of the medical record revealed there was no documentation Resident #17 had a wheelchair seat belt restraint, consent, risk and benefits of restraint use, restraint assessment, physician order, medical symptom for use or monitoring for the seat belt. A record review of the Admission Record revealed the facility admitted Resident #17 on 6/18/2022 and he had current diagnoses including Acquired Absence of Right Leg and Left Leg, Above the Knee. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/4/24 revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. On 05/30/24 at 11:06 AM, in an interview with the Director of Nursing (DON) she stated the facility did not consider the lap belt for Resident #17 as a restraint because they viewed it as a support device for the resident. She confirmed that by definition, it should have been considered a restraint and the facility should have obtained a physician's order for the device.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan related to a seat belt restraint for one (1) of 15 care plans reviewed. Residents #17 Findings Include: Review of the facility's policy, Comprehensive Care Plans revised 8/24/22, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs .Policy Explanation and Compliance Guidelines .3. The comprehensive care plan will describe .a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . During an observation and interview on 05/29/24 at 2:26 PM, Certified Nursing Assistant (CNA) #1 stated Resident #17 was unable to use his hands and could not release the seat belt buckle without assistance. Resident #17 was sitting in his wheelchair with the seat belt device in place. CNA #1 asked Resident #17 to unbuckle his seat belt, but he said that he could not unbuckle it and asked the CNA to do it. A record review of the Comprehensive Care Plan revealed there was no care plan developed related to the seat belt device worn by Resident #17. During an interview, on 05/30/24 at 11:06 AM, with the Director of Nursing (DON) she stated the facility did not consider the lap belt for Resident #17 as a restraint but rather it was viewed as a support device for the resident. However, it should have been considered a restraint and a care plan should have been developed for the device. On 5/30/24 at 11:26 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reviewed the comprehensive care plan for Resident #17 and confirmed there was no care plan related to the use of the seatbelt. She confirmed the facility should have developed a care plan for the device and stated she was not sure why it was not developed. A record review of the Admission Record revealed the facility admitted Resident #17 on 6/18/2022 and he had current diagnoses including Acquired Absence of Right Leg and Left Leg, Above the Knee.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47873 Based on observation, staff interview, and facility policy review, the facility failed to discard expired medications from one (1) of three (3) medication storage rooms observed. (Central Station) Findings include: Record Review of the facility's Medication Storage, revised 07/17/23, revealed, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the .medication rooms according to the manufacturer's recommendations .Policy Explanation and Compliance Guidelines .8. Unused Medications: The .medication rooms are routinely inspected by the consultant pharmacist for discontinued . medication with worn. In an observation and interview with Registered Nurse (RN) #2, on 5/28/24 at 11:33 AM, on central station there were expired medications in a cubicle in the medication room stored in blister packs (dose packaging for pharmaceutical tablets or capsules) for Resident #36. The medications included Furosemide 40 milligrams (mg) that expired on 1/2/24, Vistaril 25 mg expired on 1/2/24, Aricept 20 mg expired on 10/28/23, and Zoloft 25 mg expired on 2/27/24. RN #2 explained that all nurses should check the medication rooms and medication carts to ensure there were no expired medications. During an interview with the Director of Nursing (DON) on 05/30/24 at 11:39 AM, she stated it was her expectation that the nurses check medications for expiration dates before administering them and to remove expired medications from the medication carts and medication rooms. 50751