STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255158	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Care Center of Hattiesburg	10 Medical Boulevard Hattiesburg, MS 39401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on interview, record review, and facility policy review, the facility failed to assist a resident's representative with formulating an advance directive in a timely manner for one (1) of (18) sampled residents. Resident #4.Findings include:A review of the facility's policy, Resident's Rights Regarding Treatment and Advance Directives, revised 11/1/22, revealed, .It is the policy of this facility to support and facilitate a resident right to.formulate an advanced directive.Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advanced directive. 2. The facility will provide the resident's representative with information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive.A record review of the admission Record revealed the facility admitted Resident #4 on 8/22/23 with diagnoses that included End Stage Renal Disease.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident's cognition was severely impaired.A record review of the Acknowledgement of Advance Directives Decisions, Rights and Information, dated 6/11/24, revealed Resident #4's Resident Representative (RR) requested assistance with formulating an advance directive.On 03/04/26 at 9:59 AM, during an interview, Resident #4's daughter stated she received information regarding the resident's code status; however, she had not been assisted with understanding or formulating an advance directive and stated she did not understand the difference between the documents.On 03/04/26 at 10:00 AM, during an interview, the Licensed Master Social Worker (LMSW) she stated she was not the social worker assigned when Resident #4 was admitted to the facility and confirmed there was no documentation indicating the resident's representative had been assisted with formulating an advance directive.On 03/04/26 at 12:05 PM, during an interview, the Administrator stated she expects staff to assist residents and their representatives with formulating advance directives when assistance is requested.

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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, record review, and facility policy review, the facility failed to maintain a safe, clean, comfortable, and homelike environment when damaged paint and exposed sheetrock were observed in resident bedrooms for three (3) of (18) sampled resident rooms. Residents #1, #79 and #87.Findings include:A review of the facility's policy, Safe Homelike Environment, revised 7/1/23, revealed .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.Policy Explanation and Compliance Guidelines: 1. The facility will create and maintain, to the extent possible, a homelike environment.3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.A review of the facility's policy, Resident Rights, revised 10/2022, revealed .It is the policy of this facility to uphold and comply with the Resident Rights as stated in this policy.Policy Explanation and Compliance Guidelines.8. Safe environment. The resident has the right to a safe, clean, comfortable, and homelike environment.Resident #1A record review of the admission Record revealed the facility admitted Resident #1 on 10/3/23 with diagnoses including Acute Respiratory Failure with Hypoxia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (13), which indicated the resident was cognitively intact.On 3/2/26 at 2:36 PM, during an observation, scarring and exposed sheetrock were observed on the wall behind the recliner in Resident #1's room.On 3/5/26 at 9:20 AM, during an observation and interview, Housekeeping/Maintenance Staff #1 (HKM #1) observed the wall in Resident #1's room and confirmed paint scratches and exposed sheetrock were present.Resident #79A record review of the admission Record revealed the facility admitted Resident #79 on 1/22/24 with diagnoses including Unspecified Atrial Fibrillation.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/26 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired.On 3/2/26 at 11:40 AM, during an observation, a heavily scuffed wall was observed behind the bed in Resident #79's room. The wall behind the right side of the bed contained extensive scuff marks and visible damage. The damaged wall surface appeared worn and did not present a homelike environment. During the observation, Resident #79 stated he was not sure what had caused the damage.Resident #87A record review of the admission Record revealed the facility admitted Resident #87 on 9/22/23 with diagnoses including Dysphasia following Cerebral Infarction.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/26 revealed Resident #87 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired.On 3/2/26 at 12:32 PM, during an observation, chipped paint and scuffs were observed on the wall behind the bed in Resident #87's room. The damaged paint and scuffs made the wall appear worn and not homelike.On 3/5/26 at 8:50 AM, during an interview, Housekeeping/Maintenance Staff #1 (HKM #1) stated monthly room checks were conducted, and repairs were completed through maintenance work orders or invoice requests. HKM #1 stated that when entering resident rooms he observed for needed repairs, including checking call lights and other room fixtures. HKM #1 further stated that each department had assigned rooms to check daily and acknowledged several rooms required repair and repainting. HKM #1 stated that with movable furniture and beds that raise and lower, wall damage and scratches can occur over time. HKM #1 further stated that prior to the survey team entering the facility there was no plan in place to patch or repaint the damaged walls in the identified resident rooms.On 3/5/26 at 9:20 AM, during an observation and interview, Housekeeping/Maintenance Staff #1 (HKM #1) observed the wall in Resident #87's room and confirmed paint scratches were present.On 3/5/26 at 1:59 PM, during an interview, the Administrator stated the facility had difficulty hiring a painter and stated this had been (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an issue since approximately November or December 2025. The Administrator stated each department conducted daily room rounds to monitor needed repairs and staff assigned to complete these checks rotated approximately every two weeks to allow for a fresh review of resident rooms. The Administrator further stated the plan and expectation was to repair the most damaged rooms first and then continue repairing and maintaining paint in other resident rooms.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, record review, and facility policy review, the facility failed to revise a resident's comprehensive care plan after the discontinuation of psychotropic and antidepressant medications for one (1) of two (2) residents sampled for mood and behaviors. Resident #11.Findings include:A review of the facility's policy, Care Plan Revisions Upon Status Change, revised 8/2/22, revealed .The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan . f. Care plans will be modified as needed by the MDS (Minimum Data Set) Coordinator or other designated staff member . h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs .A record review of the Care Plan Report with a revision date of 1/9/26 revealed active care plan problems which stated, Problem: The resident uses psychotropic medications r/t (related to) Impulsive Aggression . Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q (every) shift . and .Problem: The resident uses antidepressant medication r/t Depression/Anxiety . Interventions: Administer antidepressant medication as ordered by physician. Monitor/document side effects and effectiveness Q-shift .A record review of the admission Record revealed the facility admitted Resident #11 on 9/20/21 with diagnoses including Schizophrenia, Unspecified with onset date of 8/12/22, Major Depressive Disorder, Recurrent, Mild with onset date of 8/15/22, and Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety with onset date of 10/2/22.A record review of Resident #11's Order Summary Report revealed there were no active orders for psychotropic or antidepressant medications related to the resident's diagnoses of Schizophrenia or Depression.A record review of the Clinical Physician Orders with last order review dated 2/24/26 revealed previously ordered psychotropic and antidepressant medications had been discontinued. Mirtazapine was discontinued on 6/10/25, Sertraline HCL was discontinued on 5/30/25, and Risperidone was discontinued on 12/16/24.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/26 revealed Resident #11 was rarely/never understood and required a Staff Assessment for Mental Status. The resident's daily cognitive decision-making skills were assessed as severely impaired. Section I revealed diagnoses of Non-Alzheimer's Dementia, Depression (other than Bipolar), and Schizophrenia.On 3/2/26 at 11:11 AM, during an observation, Resident #11 was lying in bed with the bed in the lowest position. Resident #11 did not speak when spoken to.On 3/3/26 at 1:24 PM, during an interview, Licensed Practical Nurse (LPN) #2 stated Resident #11 was nonverbal and had not demonstrated combative behaviors but could occasionally be resistant when receiving medications. LPN #2 stated Resident #11 currently received Memantine and an Exelon patch for Dementia and confirmed the resident was not receiving any psychotropic medications.On 3/5/26 at 1:51 PM, during a record review and interview, LPN #3 stated residents' care plans were updated and revised as changes occurred in physician orders or resident status. LPN #3 confirmed Resident #11 had a care plan revision on 1/9/26 and a Quarterly MDS with an Assessment Reference Date of 1/27/26. After reviewing Resident #11's physician orders and care plan, LPN #3 confirmed the resident was no longer receiving psychotropic or antidepressant medications; however, the care plan continued to include interventions directing staff to administer psychotropic and antidepressant medications and monitor for side effects. LPN #3 stated the interventions were generic and automatically populated during care plan review and acknowledged the care plan had not been resolved after the medications were discontinued.On (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/5/26 at 2:54 PM, during an interview, the Director of Nursing (DON) stated she expected nursing staff responsible for care planning to revise residents' care plans when physician orders changed and ensure care plans accurately reflected the resident's current condition and treatment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was administered an inhaler medication in accordance with professional standards and manufacturer guidelines for one (1) of three (3) inhaler medication administrations observed. Resident #38.Findings include:A review of the facility's Administration of Metered-Dose Inhaler, dated 4/4/24, revealed, .It is the policy of this facility to ensure medications are administered.in accordance with professional standards of practice.Policy Explanation and Guidelines.16. If using a corticosteroid, allow resident to rinse and gargle with water if desired, to remove medication from mouth and back of throat.On 03/03/26 at 8:30 AM, during an observation, Licensed Practical Nurse (LPN) #2 administered Trelegy Ellipta inhaler aerosol 100-62.5-25 MCG/ACT (micrograms/actuation), one puff orally, to Resident #38 and did not instruct the resident to rinse their mouth with water after the medication was inhaled.A record review of the manufacturer's guidelines for Trelegy Ellipta revealed, .Step 6.Rinse your mouth with water after you have inhaled the medication. Do not swallow the water.On 03/03/26 at 3:30 PM, during an interview, LPN #2 confirmed she did not instruct Resident #38 to rinse his mouth after administering the corticosteroid inhaler and stated she was unaware of the potential side effects.On 03/03/26 at 3:45 PM, during an interview, the Director of Nursing (DON) stated staff should instruct residents to rinse their mouths after using corticosteroid inhalers and stated the resident should spit the water out to help prevent oral thrush.On 03/03/26 at 4:00 PM, during an interview, the Administrator stated staff are expected to follow the medication administration policy and manufacturer guidelines when administering medications.A record review of the admission Record revealed the facility admitted Resident #38 on 6/2/25 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/26 revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.A record review of the Order Summary Report revealed Resident #38 had a Physician's order, dated 6/2/25, for Trelegy Ellipta inhalation aerosol powder breath activated.1 (one) puff inhale orally one time a day for COPD.A record review of the Medication Administration Record for March 2026 revealed Resident #38 was administered Trelegy Ellipta inhaler on 3/3/26 at 8:30 AM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and facility policy review, the facility failed to properly store oxygen cylinders and post required cautionary signage related to an oxygen cylinder stored in a resident's room for one (1) of (18) sampled residents. Resident #15.Findings include:A review of the facility's policy, Medication Storage, revised 07/17/23, revealed, .Policy Explanation and Compliance Guidelines.6 .Oxygen Cylinders will be stored in a designated Oxygen storage room.On 03/02/26 at 12:13 PM, during an observation, an oxygen concentrator and an oxygen cylinder were in the corner of Resident #15's room. There was no oxygen cautionary signage on the resident's door. Resident #15 was lying in bed asleep. The oxygen cylinder nor the oxygen concentrator were in use by the resident. On 03/03/26 at 3:20 PM, during an observation, the oxygen concentrator and cylinder continued to be stored in the corner of Resident #15's room and there was no oxygen signage outside of the door.A record review of the admission Record revealed the facility admitted Resident #15 on 11/17/25 with diagnoses including Unspecified Dementia.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25 revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 00, indicating her cognition was severely impaired.A record review of the Medication Review Report revealed that Resident #15 had no physician orders for oxygen therapy. There was a physician's order, dated 12/5/25, for Resident #15 to be admitted to hospice services on 12/5/2025. On 03/03/26 at 3:31 PM, during an observation and interview, Licensed Practical Nurse (LPN) #1 confirmed an oxygen concentrator and cylinder were stored in Resident #15's room and confirmed there was no oxygen sign posted on the door. LPN #1 stated she did not know why the equipment was in the resident's room and stated the resident did not have a facility order for oxygen.On 03/03/26 at 3:55 PM, during an observation and interview, Registered Nurse (RN) #1 confirmed an oxygen concentrator and cylinder were located in Resident #15's room and confirmed there was no oxygen cautionary sign on the door. RN #1 stated the hospice company may have brought the equipment and stated she did not know why the equipment was stored in the resident's room.On 03/03/26 at 4:20 PM, during an observation and interview, the Director of Nursing (DON) confirmed an oxygen concentrator and cylinder were located in Resident #15's room and there was no oxygen cautionary sign on the door. The DON stated the equipment should not remain stored in the resident's room and stated oxygen signage should be posted where oxygen equipment is present.On 03/03/26 at 4:30 PM, during an interview, the Administrator stated staff are expected to follow the facility's oxygen storage and safety policies to ensure resident safety.