STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255343	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Care Center of Picayune	2797 Cooper Road Picayune, MS 39466

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on staff interview, record review, and facility policy review, the facility failed to ensure resident medications were protected from misappropriation for one (1) of four (4) medication carts. Findings include:A review of the facility's policy Abuse, Neglect and Exploitation, Revised 2/3/26 revealed, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Definitions.Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful.use of a resident's belongings or money without the resident's consent. A record review of the facility's investigation Alleged Medication Diversion, dated 3/13/26, revealed that on 3/12/26 during the 7:00 PM shift change narcotic count the following medications were missing from the narcotic box on one medication cart: Resident #1, four (4) Percocet 5-325 mg (milligrams); Resident #2, one (1) Percocet 10-325 mg; Resident #3, two (2) Norco 5-325 mg; and Resident #4, one (1) Norco 7.5-325 mg, all oral medications. Further investigation revealed Licensed Practical Nurse (LPN) #1 reported on 3/12/26 during the day shift she provided her medication cart narcotic keys to Registered Nurse (RN) #1 while she was performing a urine specimen collection. LPN #1 confirmed the narcotic count was correct earlier on 3/12/26; however, upon returning, she observed the medication cart in the nurses' station and unlocked. RN #1 later confirmed she did not administer any medications, despite having moved the medication cart into the nurses' station. Discrepancies were identified during the shift change narcotic count on 3/12/26 at 7:00 PM. RN #1 admitted to not administering any medications to residents during the period she had possession of LPN #1's medication cart keys. The facility placed both RN #1 and LPN #1 on suspension pending the investigation. An in-house drug screen performed on both nurses revealed LPN #1 tested negative for all 10 panels, and RN #1 tested positive for oxycodone. RN #1 reported she had taken an oxycodone tablet on March 10 or 11, 2026, for dental pain and provided an outdated prescription dated August 2025. The facility's corrective actions included staff education regarding key control, medication security, and proper reporting procedures. The facility performed in-services with all nursing staff covering controlled substance accountability, cart and key security, chain of custody protocols, and immediate reporting requirements. The facility notified the pharmacy of the missing narcotics and paid for the replacement of all missing controlled substances. On 3/13/26, the facility reported the incident to the Board of Nursing, Board of Pharmacy, Office of Inspector General, and State Agency (SA). The conclusion of the facility investigation revealed there were missing controlled medications, unauthorized handling of a medication cart, and a positive drug screen for RN #1. All required corrective actions, notifications, and staff education were completed prior to the SA entering the facility on 3/30/26.Resident #1A record review of the admission Record, revealed the facility admitted Resident #1 on 12/6/24 with diagnoses including Dementia.A record review of the Order Audit Report, revealed Resident #1 had a physician's order, dated 0/10/25 for Oxycodone-Acetaminophen Tablet 5-325 mg to be given 1 (one) tablet by mouth every 12 hours as needed for pain.A record review of the facility's Individual Patient Narcotic-Controlled Drug log revealed on 2/27/25 at 1:11 AM, Oxycod (Oxycodone)- APAP (Acetaminophen) Tablet 5-325 mg, one (continued on next page)

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) tablet was documented as administered to Resident #1 with a remaining balance of 20 tablets. On 3/12/26, the log had an entry to correct the count to 16 tablets to indicate there were four (4) missing tablets.Resident #2A record review of the admission Record revealed the facility admitted Resident #2 on 3/9/26 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the Order Audit Report, revealed Resident #2 had a physician's order, dated 3/9/26 for Oxycodone-Acetaminophen Oral Tablet 10-325 MG to be given one (1) tablet by mouth every eight (8) hours as needed for pain. A record review of the facility's Individual Patient Narcotic-Controlled Drug log revealed on 3/12/26 at 7:01 PM, Oxycod (Oxycodone)-APAP (Acetaminophen) Tablet10-325 mg, one (1) tablet was documented as administered to Resident #2 with a remaining balance of five (5) tablets. On 3/12/26, the log had an entry to correct the count to four (4) tablets to indicate there was one (1) missing tablet. Resident #3A record review of the admission Record revealed the facility initially admitted Resident #3 on 3/15/23 with diagnoses including Dysphasia.A record review of the Order Audit Report, revealed Resident #3 had a physician's order, dated 7/23/25 for Hydrocodone-Acetaminophen Tablet 5-325 mg, to be given one (1) tablet by mouth every 24 hours as needed for pain.A record review of the facility's Individual Patient Narcotic-Controlled Drug log revealed on 7/29/25 at 5:00 PM, Resident #3 had two (2) tablets of Hydrocodone/APAP 5-325 mg tablets when he returned from being out on pass. There was no medication administrations documented. On 3/12/26, the log had an entry to correct the count to zero (0) tablets to indicate there were two (2) missing tablets. Resident #4A record review of the admission Record revealed the facility admitted Resident #4 on 1/25/24 with diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy.A record review of the Order Audit Report revealed Resident #4 had a physician's order, dated 1/14/26 for Hydrocodone-Acetaminophen Tablet 7.5-325 mg, to be given one (1) tablet every six (6) as needed for pain.A record review of the facility's Individual Patient Narcotic-Controlled Drug log revealed on 3/12/26 at 2:05 PM, Hyrocodone-APAP Tablet 7.5-325, one (1) tablet was documented as administered to Resident #4 with a remaining balance of eight (8) tablets. On 3/12/26, the log had an entry to correct the count to seven (7) tablets to indicate there was one (1) missing tablet. On 3/31/26 at 10:50 AM, during an interview with LPN #1, she confirmed that on 3/12/26, following the 7:00 AM narcotic count, all controlled substance counts were correct when she received the medication cart keys. She revealed that during the 7:15 PM narcotic count, discrepancies were identified involving four (4) residents, with medications missing from the medication packs for four (4) residents. She confirmed that she and the relieving nurse conducted a thorough search of the medication cart and nurses' station to determine if the medications were misplaced; however, the medications were not located, and she notified the Director of Nursing (DON) immediately. She revealed that earlier in the shift she provided the medication cart keys to RN #1, without completing a narcotic count before or after transferring the keys, which was not in accordance with facility policy. She said she was suspended while the facility completed an investigation. She confirmed a drug screen was completed and returned negative, and she received additional education on narcotic/medication key control, medication security, and reporting procedures.On 3/31/26 at 10:55 AM, during an interview with RN #1, she confirmed she was present in the facility and had received the medication cart keys from another nurse to monitor the cart; however, she denied taking any narcotics. She reported that, since she was new, she moved the medication cart into the nurses' station so she could observe it. RN #1 further reported she would never take a resident's narcotics.On 3/31/26 at 11:10 AM, during a phone interview with the Director of Pharmacy, she confirmed the facility notified the pharmacy on 3/12/26 regarding missing controlled substances involving four (4) residents. She revealed a reconciliation was conducted comparing dispensing records, delivery logs, and expected on-hand quantities, which confirmed discrepancies consistent with missing controlled substances for the identified residents. She confirmed the medications had been dispensed appropriately to the facility and the discrepancy did not originate from the pharmacy. She revealed the incident met criteria for misappropriation of resident property and required reporting to applicable (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regulatory agencies. She further confirmed the pharmacy collaborated with the facility to replace the missing medications, provided guidance on controlled substance accountability, and recommended ongoing audits and strict adherence to chain of custody and key control procedures to prevent recurrence.On 3/31/26 at 1:50 PM, during an interview with the Director of Nursing (DON), she confirmed the facility identified a narcotic discrepancy on 3/12/26 during the evening count involving multiple residents. She revealed the facility's expectation is that medication cart keys remain secured with the assigned nurse at all times and that a narcotic count is completed whenever keys are transferred. She said that this process was not followed when the LPN #1 provided the keys to RN #1 without completing a count. The DON revealed the facility immediately initiated an investigation whenever the narcotic count indicated missing medications and LPN #1 and RN #1 were suspended during the investigation. She also confirmed the facility completed drug testing on the two (2) nurses, notified appropriate agencies, and implemented corrective actions including staff re-education, audits, and Quality Assurance Performance Improvement (QAPI) review to prevent recurrence. The DON confirmed that RN #1's hire date was 2/10/26 and her last day worked was 3/12/26. She was terminated on 3/13/26 due to the suspected drug diversion. The DON confirmed a background check and nursing license verification were completed for RN #1, and her nursing license was unencumbered, with no restrictions or disciplinary actions. On 3/31/26 at 2:00 PM, during an interview with the Administrator, he confirmed the facility identified missing controlled substances on 3/12/26 involving our (4) residents. He revealed the facility's expectation is that all narcotics are secured at all times and that staff follow strict key control and chain of custody procedures, which were not followed in this instance. He confirmed the facility immediately removed involved staff from duty, initiated an investigation, and reported the incident to the appropriate agencies. He revealed corrective actions were implemented, including staff education, increased audits, and QAPI review, to ensure ongoing compliance and prevent recurrence. He confirmed that on 3/16/26, the facility conducted an emergency QAPI meeting with the following in attendance: Medical Director, Administrator, Director of Nursing (DON), Infection Preventionist, Staff Development Coordinator, Social Services, Business Office Manager, Minimum Data Set (MDS) Coordinator, Medical Records, Maintenance, and Dietary Manager.Based on the facility's implementation of corrective actions completed on 3/16/26, the SA determined the deficiencies to be Past Non-Compliance (PNC) and the facility was in compliance prior to the SA's entrance on 3/30/26.Validation:The SA validated on 3/31/26 through interview and record review, that all corrective actions had been implemented as of 3/16/26 and the facility was in compliance, prior to the SA's entrance on 3/30/26. A review of the Audit-Weekly Count Audit revealed the DON is monitoring the accuracy of the narcotic count weekly.