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	05/23/2024

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

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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 - Many	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 32 residents reviewed for advance directives. (Resident #100). This deficient practice had the potential to affect all residents who had a durable POA. 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 . Record review of the Acknowledgement of Advance Directives Decisions, Rights, and Information, signed 2/9/24, which was located in the electronic health record and signed by the Resident Representative (RR), indicated Resident #100 had a Living Will. Upon review of the medical record, there was no copy of an advance directive or POA located in the medical chart. On 5/20/24 at 1:15 PM, in an interview and record review with Registered Nurse (RN) #1, she stated advance directives are in the resident's electronic chart and reviewed the electronic health record for Resident #100. She acknowledged there was no advance directive located under the Misc (Miscellaneous) tab of the electronic chart. She confirmed there were no paper charts or other areas of the nurse's station where advance directives would be kept. She commented that if a resident had an advance directive, she thought it would be listed under the Special Instructions which was readily viewable by all staff. She confirmed there were no instructions listed on the special instructions section for Resident #100. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/20/24 at 1:45 PM, in an interview with the Director of Nursing (DON), she revealed Resident #100 did not have a living will but clarified the RR had provided a POA to the facility and he had incorrectly checked the Living Will while electronically signing the admission paperwork. The DON explained the POA could be viewed on the Administration Side of the electronic health record and not the Clinical Side, which meant the POA could not be viewed by nurses or clinical staff. The DON provided a paper copy of Resident #100's POA and advised she would have the POA scanned into the Misc tab on the electronic medical record. On 5/20/24 at 1:56 PM, in an interview with the Admission Coordinator, she explained she was responsible for discussing advance directives with residents and the RR upon admission to the facility. She stated if a resident had a POA, she kept a copy in a binder. She further explained the binder was in an office that was locked after hours and on weekends, and was located in Building 2, which was a separate building from Building 1. The Admissions Coordinator confirmed POAs were not readily retrievable by facility staff. A record review of the Admission Record revealed the facility admitted Resident #100 on 2/22/24 and she had current diagnoses including Hemiplegia and Hemiparesis.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44179 Based on staff interview, record review, and facility policy review, the facility failed to revise comprehensive care plan interventions related to oxygen therapy (Resident #3), pain management (Resident #103), and trauma-informed care (Resident #62) for three (3) of 21 sampled residents. Findings include: A review of the facility's policy, Comprehensive Care Plans, revised 8/24/22, revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . Definitions . Trauma-Informed care is an approach to delivering care that involves understanding, recognizing, and responding to effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans .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 .g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effort of the trigger on the resident . Resident #3 A record review of the comprehensive care plan with a date initiated of 5/1/2024 revealed Problem The resident has COPD (Chronic obstructive pulmonary disease) .Interventions .Oxygen Settings: O2 via nasal cannula @ 2L continuously . Further review revealed a Problem of The resident has oxygen therapy r/t (related to) Ineffective gas exchange with Interventions of Oxygen settings: O2 via NC 2/L .PRN (as needed). A record review of the Order Summary Report, with active orders as of 5/21/24, revealed Resident #3 had a Physician's Order, dated 3/20/24, for O2 (Oxygen) at 2L/min (liters per minute), TITRATE TO KEEP O2 SATS (Saturation) > 92%. A record review of the Admission Record revealed the facility admitted Resident #3 on 1/6/22 and she had current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). On 5/21/24 at 2:30 PM, in an interview with Registered Nurse (RN) #5, she confirmed Resident #3 had a physician's order to titrate her oxygen which meant it should be applied as needed to keep her oxygen saturation above 92%. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 2:51 PM, in an interview with RN #2, she confirmed the comprehensive care plan for Resident #3 had conflicting oxygen orders because one care plan indicated the oxygen was used continuously and the other care plan indicated the oxygen was to be used as needed. She explained the staff had been auditing care plan and reconciling them with orders and this care revision could have been missed. She stated she expected the facility staff to follow the care plan and to advise the care plan nurse if there were conflicting interventions. Resident #103 A record review of the comprehensive care plan with a date initiated of 3/29/204, revealed Problem The resident has acute/chronic pain r/t (related to) Disease process CANCER .Interventions .Fentanyl Patch 72 HR 25 MCG/HR (Micrograms/Hour) Q72H (every 72 hours) for Pain . There was no care plan intervention addressing the Physician's Order for morphine sulfate. A record review of the Order Summary Report, with active orders as of 5/22/24, revealed Resident #103 had a Physician's Order, dated 4/18/24, for Fentanyl Transdermal Patch 72 Hour 75 MCG/HR (micrograms/hour) and an order dated 5/17/24 for Morphine Sulfate .10 MG (milligrams)/0.5 ml (milliliters) q (every) 4 hours for pain. A record review of the Admission Record revealed the facility admitted Resident #103 on 3/8/24 and she had current medical diagnoses including Malignant Neoplasm of the Ovary, Colon, and Rectum. On 5/22/24 at 9:50 AM, in an interview with RN #2, she explained she was the Minimum Data Set (MDS) nurse. She stated the facility ran a report every day and reviewed all new physician orders that were written. The care plan nurse then revised the care plan for residents based on the physician's orders. On 5/22/24 at 10:03 AM, in an interview with Licensed Practical Nurse (LPN #1), she explained that she was responsible for updating or revising the care plans. She confirmed Resident #103's care plan was not revised to include recent physician orders to increase the Fentanyl patch to 75 mcg and to add morphine sulfate. She stated the staff tried to review care plans periodically to ensure they accurately reflected the resident's care and physician's orders. On 5/22/24 at 10:30 AM, in an interview with the Director of Nursing (DON), she stated she expected resident care plans to be accurate and match the resident's orders and confirmed care plans were used by staff to provide care to the residents. Resident #62 A record review of the comprehensive care plan for Resident #62, undated, revealed Problem The resident has potential for psychosocial well-being r/t (related to) hx (history) of PTSD . The care plan was not revised to include interventions to identify triggers and prevent re-traumatization of the resident. Record review of the Admission Record revealed the facility admitted Resident #62 on 11/13/2023 and he had a diagnosis of Post Traumatic Stress Disorder (PTSD) with an onset date of 11/13/2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/22/23, revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated his cognition was moderately impaired. Further review of Section I for Active Diagnoses revealed he had a diagnosis of PTSD. On 05/23/24 at 9:45 AM, an interview with Licensed Practical Nurse (LPN) #1, she confirmed the care plan was not revised for Resident #62 related to the diagnosis of PTSD, including information regarding the resident's triggers. She reviewed the electronic medical record and stated she would review her information and revise the residents care plan. On 05/23/24 at 9:50 AM, during an interview with the Social Services (SS) Designee, confirmed that a care plan with interventions would be helpful for staff to know how to care for the resident to avoid re-traumatization. On 05/23/24 at 9:55 AM, in an interview with the Director of Nursing (DON), she stated she expected the facility to revise comprehensive care plans related to residents with PTSD to include the triggers for residents. She also stated that she expected the care plan to contain interventions to prevent re-traumatization of the residents. 37415

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44179 Based on observation, staff interview, and record review, the facility failed to store an O2 (Oxygen) nasal cannula and a nebulizer mask in a designated container and failed to change or discard a disposable humidifier water bottle timely for one (1) of two (2) residents reviewed for oxygen therapy. Resident #3 Findings include: Record review of the facility's policy, Oxygen Administration, revised 8/2/22, revealed Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration . However, the policy did not address O2 and Nebulizer tubing storage or changing the disposable water humidifier bottle. On 5/20/24 at 9:13 AM, Resident #3 was observed sleeping in bed. She was not wearing oxygen and there was an O2 concentrator located next to the bed and bedside table. There was a nasal cannula tubing wrapped around the concentrator and not stored in a bag. The disposable humidifier water bottle attached to the concentrator had a handwritten date of 12/21/23, was half full, and was attached to a nasal cannula tubing that was dated 5/16/24. There was a nebulizer machine on the bedside table and the mask was hanging down the side of the bedside table and not stored in a designated bag or container. A record review of the Admission Record revealed the facility admitted Resident #3 on 1/6/22 and she had current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the Order Summary Report, with active orders as of 5/21/24, revealed Resident #3 had a Physician's Order, dated 3/20/24, for O2 (Oxygen) at 2L/min (liters per minute), TITRATE TO KEEP O2 SATS (Saturation) > 92% and a Physician's Order, dated 11/20/23 for Ipratropium-Albuterol Solution 0.5-2.5 . 1 vial inhale orally every 12 hours as needed . On 5/21/24 at 2:10 PM, an interview with Licensed Practical Nurse (LPN) #2 revealed Resident #3 was not currently using oxygen because it was ordered as needed and LPN #2 stated the resident had not needed to wear it recently. He stated that he did not look at the oxygen water humidifier bottle or how the tubing was stored because the night shift staff were responsible for changing those out weekly. On 5/21/24 at 2:30 PM, in an interview and observation in Resident #3's room with Registered Nurse (RN) #5, she confirmed the O2 nasal cannula and nebulizer mask were not stored in a designated container and stated they should have been stored in a bag. She also verified the O2 concentrator water humidifier bottle was dated 12/21/23 and thought it should be changed weekly. On 5/22/24 at 10:30 AM, in an interview with the Director of Nursing (DON), she stated she expected oxygen nasal cannula tubing and nebulizer masks to be stored appropriately and for staff to change or discard oxygen humidifier bottles timely.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 37415 Based on interviews, record review, and facility policy review, the facility failed to ensure triggers and resident specific interventions were identified and initiated for a resident with Post Traumatic Stress Disorder (PTSD) for one (1) of 21 sampled residents. Resident #62 Findings include: A review of the facility's policy, Trauma Informed Care, revised 6/1/23, revealed, .It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re -traumatization .Policy Explanation and Compliance Guidelines .2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools .4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other care professionals .to develop and implement individualized care plan interventions. 5. The facility will identify triggers which may re-traumatize residents with the history of trauma. Trigger- specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan .9. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident . Record review of the Admission Record revealed the facility admitted Resident #62 on 11/13/2023 and he had a diagnosis of PTSD with an onset date of 11/13/2023. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/22/23, revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated his cognition was moderately impaired. Further review of Section I for Active Diagnoses revealed he had a diagnosis of PTSD. A record review of the Life History document, dated 11/14/23, indicated Resident #62 had experienced physical, mental abuse, trauma, traumatic experience are significant fears in the past and resident . attempted to commit suicide a few years ago . A record review of the facility's .Trauma Screening Questionnaire, dated 11/15/23, revealed in Section 3 Resident has been evaluated and treated related to history of PTSD. A review of the medical record revealed there was no documentation that indicated Resident #62 was evaluated to identify triggers and resident specific interventions regarding his history of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/24 at 8:30 AM, Certified Nurse Aide (CNA) #2 stated Resident #62 was admitted to the facility in November and she was not sure what type of previous trauma the resident had or what things might trigger the resident to cause re-traumatization. She said that any information regarding how to care for the resident was located on the Kardex (summary of resident information). CNA #2 went to a kiosk in the hallway, signed in, and reviewed Resident #62's information. She confirmed there was no information regarding the resident's triggers that may cause re-traumatization. In an interview on 5/23/24 at 8:40 AM, with Licensed Practical Nurse (LPN) #3, she confirmed Resident #62 was admitted in November 2023 and she was not aware of any triggers that may cause re-traumatization to the resident. She stated that behavior interventions would be on the resident's care plan, and she signed in on the computer to review the care plan. She confirmed there was nothing in place as to what triggers the resident. During an interview on 5/23/24 at 9:50 AM, with the Social Services Director (SSD), she confirmed the facility had not provided trauma informed care for Resident #62 because they were not aware of the triggers that could cause re-traumatization. The SSD stated Resident #62 had previously been hospitalized at the Veteran's Administration (VA) hospital. The resident's sister had signed him in and advised he had previously suffered from a nervous breakdown. The SSD reported Resident #62 had a diagnosis of PTSD when he left the VA hospital. She confirmed she completed a trauma screen on the resident which revealed the resident had a history of PTSD. The SSD said the resident's sister did not know what triggered the resident because previously he lived alone. The SSD confirmed she had not attempted to obtain information from the VA hospital regarding his history of PTSD and the triggers that could cause re-traumatization. During an interview on 5/23/24 at 9:55 AM, the Director of Nursing (DON), stated she expected the facility to provide trauma informed care for residents with PTSD so they would know what the triggers were for residents to prevent re-traumatization. During an interview on 05/23/24 at 10:14 AM, with the facility's Administrator, stated that he expected a resident who had PTSD to receive trauma informed care to ensure that a resident was not re-traumatized.

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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 stock medications for one (1) of five (5) medication storage areas reviewed. Nurses Station-Building 1 Findings include: Review of the facility policy, Medication Storage, revised 7/17/23, revealed, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the in the pharmacy and/or medication rooms according to the manufacturer's recommendations .Policy Explanation and Compliance Guidelines .8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective or deteriorated medications with worn illegible or missing labels. On 05/20/24 at 9:16 AM, during an observation, there were expired medications in the medication storage area of the nurses' station in Building 1. The expired stock medications were Magnesium 750 milligrams (mg), which had an expiration date of 12/2023, Folic Acid 1 mg with an expiration date of 1/2024, and Aspirin 325 mg with an expiration date of 1/2024. On 05/20/24 at 10:14 AM, during an interview and observation with Registered Nurse (RN) # 1, she confirmed the Magnesium, Folic Acid, and Aspirin were expired and should not be in the stock medication area. She stated it was the cart nurses' responsibility to discard any expired medications from the medication carts and medication storage areas. On 05/21/24 at 10:14 AM, in an interview with the Director of Nursing (DON), she confirmed it was the responsibility of cart nurses to discard expired medications from the medication carts and from the medication storage areas. She stated she expected the nurses to follow up and check for expired medications in facility stock and carts. She explained that using expired medications could be a potential hazard as the efficacy of the medication could have changed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 Based on observation, staff interviews, and facility policy review, the facility failed to discard expired foods and failed to label opened foods with a use-by date for one (1) of three (3) kitchen observations. Findings include: A review of the facility's policy, Food Safety Requirements, revised [DATE], revealed, .Food will be stored .in accordance with professional standards for food safety .Policy Interpretation and Implementation .1. Food safety will be followed throughout the facility's entire food handling process .b. Storage of food in a manner that helps prevent deterioration or contamination of the food .3. Facility will inspect all food .and ensure timely and proper storage .c. Refrigerated storage .Practices to maintain safe refrigerated storage include .iv. labeling, dating, and monitoring refrigerated food . On [DATE] at 8:00 AM, during the initial tour of the kitchen with the Dietary Manager (DM) #1 of Building 1, revealed an opened gallon of buttermilk in the Cook's Refrigerator with a manufacturer's expiration date of , d+[DATE]. DM #1 confirmed the buttermilk was expired. On [DATE] at 8:00 AM, during the initial tour of the kitchen with DM #2, the walk-in refrigerator had clear containers of olives that did not have an opened or use-by date and an opened container of sour cream with no opened or use-by date. DM #2 confirmed the containers of olives and sour cream did not have a use-by date. On [DATE] at 10:12 AM, in an interview with DM #1 and DM #2, they stated it was everyone's responsibility to ensure opened foods were labeled with a use-by date and expired foods were discarded, but it was ultimately their responsibility to oversee that it was done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47873 48181 Based on observation, staff interview, and facility policy review, the facility failed to provide hand hygiene for residents prior to meals for one (1) of four (4) dining rooms observed. Dining Room C. Findings include: A record review of the facility's policy, Handwashing/Hand Hygiene revised 8/2/22, revealed, .This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation .5. Residents .will be encouraged to practice hand hygiene .7. Use an alcohol-based hand rub .or .soap .and water for the following situations .o. Before and after eating or handling food . On 5/20/24 at 10:51 AM, during an observation of Dining Room C, the facility staff did not offer to assist residents with washing or sanitizing their hands. There were four (4) Certified Nurse Aides (CNAs) and one (1) Licensed Practical Nurse (LPN) present. On 5/20/24 at 11:44 AM, during an observation, three (3) residents were assisted to the dining room table in Dining Room C by therapy staff. The residents were not offered assistance with washing or sanitizing their hands prior to the meal being served. On 5/20/24 at 11:48 AM, during an interview with the Director of Nursing (DON), she was in Dining Room C and observed the three (3) residents who came from therapy to the dining room table and staff did not offer assistance with washing or sanitizing their hands. The DON explained CNAs were responsible for assisting the residents with hand hygiene before meals. On 05/20/24 at 12:35 PM, an interview with CNA #1, she confirmed the staff did not offer to assist residents with hand hygiene in Dining Room C prior to serving lunch. On 05/20/24 at 12:40 PM, during an interview with the Physical Therapy Assistant (PTA), she reported the (3) residents that came into the dining room had just ended therapy prior to lunch. She confirmed the therapy staff do not assist residents in washing their hands before going to the dining room. She stated, Residents like to stay in the therapy room as long as they can before going to lunch.