

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Bedford Care Center of Picayune		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a required Significant Change PASRR (Preadmission Screening and Resident Review) for 1 (one) of 23 (twenty-three) sampled residents (resident #113) after the initiation of an antipsychotic medication. The facility's failure to complete the Significant Change PASRR prevented the appropriate evaluation of the resident's mental health needs and compliance with federal PASRR requirements. A record review of the Level I PASARR dated July 9, 2019, was completed prior to admission. A review of the admission Record revealed Resident #113 was admitted to the facility on [DATE], with a diagnosis of chronic systolic heart failure. A subsequent review of the admission Record revealed the resident was diagnosed with unspecified psychosis not due to a substance or known physiological condition on May 15, 2025. A review of the Significant Change in Status Minimum Data Set (MDS) with an Assessment Reference ARD) of September 19, 2025, revealed Section C documented a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment. The same Significant Change MDS, Section I, documented active diagnoses of anxiety disorder, depression, and psychotic disorder (other than schizophrenia). A review of the facility's Resident Assessment - Coordination with PASARR Program Policy, revised June 1, 2023, revealed the Social Services Director is responsible for tracking residents' PASARR screening status and referring residents to the appropriate authority. The policy further revealed any resident who exhibits newly evident or possible serious mental disorder is to be promptly referred to the state mental health or intellectual disability authority for a Level II PASARR review, including residents who receive a new order for antipsychotic or psychotropic medication when not previously taking such medications prior to admission. A review of psychiatry visit notes dated December 28, 2024, and September 14, 2025, reflected the resident was prescribed antipsychotic medication. A record review of the resident's physician orders revealed Vraylar 1.5 mg (milligrams) prescribed on January 25, 2024, and an increased dose of Vraylar 6 mg ordered on April 6, 2025, for treatment of psychosis. On December 17, 2025, at 11:29 AM, during an interview, the Social Services Director, stated that Resident #113 receives psychiatric services and was last seen by Psychiatrist, on October 25, 2025. On December 17, 2025, at 2:50 PM, during an interview, the Director of Nursing stated that the psychiatric nurse practitioner was terminated in October 2025, and the facility was actively seeking a replacement provider. She further stated that, in the interim, the Medical Director and nurse practitioner were seeing residents with lower BIMS scores until a new psychiatric provider was obtained. On December 18, 2025, at 10:30 AM, during an interview, the Social Services Director stated that Resident #113 did not have a PASARR Level II completed due to failure to submit the referral. She further stated that she was unaware that a Level II PASARR submission was required. On December 18, 2025, at 11:21 AM, during a follow-up interview and medication review with the Social Services Director, it was confirmed that Resident #113 had been prescribed psychotropic medication since December 2024 and that no Significant Change PASARR Level II referral had been submitted. On December 18, 2025, at 1:46 PM, during an interview, the State Agent informed the Administrator of the failure to complete a PASARR Level II evaluation following the (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's psychotropic medication use and documented mental health diagnoses. The Administrator stated that his expectation is for staff to follow PASARR policy requirements.		

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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. Based on interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan with appropriate interventions for a resident diagnosed with a urinary tract infection (UTI) for one (1) of 23 sampled residents, Resident #7. Findings include: A review of the facility's policy Comprehensive Care Plans with revised date 8/24/22 revealed . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.A record review of the admission Record revealed the facility admitted Resident #7 on 07/31/2025 with diagnoses including Polyneuropathy. A record review of the Results Urine Culture which was lasted resulted on 12/10/2025, revealed Resident #7 had a urine culture that was positive for greater than 100 thousand counts for an Klebsiella pneumoniae (a type of bacteria).A record review of the Order Summary Report revealed Resident #7 had a Physician's Order, dated 12/10/2025, for Cefuroxime Axetil (an antibiotic medication) with instructions to Give 1 tablet by mouth two times a day for UTI.A record review of Resident #7's medical record revealed no comprehensive care plan with interventions was developed to address the diagnosis of a urinary tract infection (UTI) or to identify the resident as at risk for UTI.On 12/16/2025 at 2:45 PM, during an interview with Licensed Practical Nurse (LPN)#1, he confirmed that Resident #7 is currently being treated with antibiotics for UTI. On 12/17/25 at 1:00 PM, during an interview with Registered Nurse (RN) #2, she explained care plans were updated when a resident had a new medication or a change in condition and were also reviewed and updated during quarterly and annual reviews.On 12/17/25 at 1:45 PM, during an interview with RN #3, she confirmed a urine culture for Resident #7 was positive with greater than 100,000 colony counts for an organism, and the resident was started on antibiotic therapy for seven (7) days for a diagnosis of Urinary Tract Infection (UTI). She confirmed Resident #7 did not have a care plan addressing the UTI diagnosis or a care plan identifying the resident as at risk for UTI.On 12/18/25 at 12:03 PM, during an interview with the Director of Nursing (DON), she explained the purpose of the care plan was to guide staff on how to care for the resident. She indicated that if a resident had a current Urinary Tract Infection (UTI) and was receiving antibiotic therapy, she would expect a care plan to be developed to inform staff of the resident's condition and identify appropriate interventions to be implemented during care.		

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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. Based on observation, interview, and facility policy review, the facility failed to store medications in a safe and secure manner for two (2) of four (4) medication carts reviewed. Findings included: A review of the facility policy, Storage of Medications, revised 8/2/22, revealed, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation.7. Compartments (including, but not limited to, carts, containing drugs and biologicals shall be locked when not in use. carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 12/17/25 at 8:05 AM, during an observation of medication pass in Building One with Licensed Practical Nurse (LPN) #1, the medication cart was observed left unattended and unlocked on the resident hallway while LPN #1 went to the medication room. The medication cart remained unattended and unlocked from 8:15 AM to 8:20 AM. On 12/17/25 at 8:21 AM, during an interview with LPN #1, he confirmed that the medication cart was left unlocked while he went to the medication room. He explained that the cart contained medications for multiple residents and acknowledged that a resident could have accessed the cart while he was away. On 12/17/25 at 8:30 AM, an observation of the contents of the medication cart revealed multiple medications stored on the cart, including over-the-counter medications such as aspirin, vitamins, acetaminophen (Tylenol), eye drops, and prescription blood pressure medications. On 12/17/25 at 10:33 AM, during an interview with the Director of Nursing (DON), she explained that medication carts are required to remain locked at all times when not in use in accordance with facility policy. She stated the purpose of locking the cart is to protect residents from accessing medications not intended for them and confirmed staff had received training multiple times related to medication cart security. On 12/17/25 from 2:50 PM to 3:03 PM, during an observation in Building Two, a medication cart was observed left unattended and unlocked on the resident hallway. On 12/17/25 at 3:04 PM, during an interview with LPN #2, she confirmed the medication cart was unlocked and then locked the cart. She explained that she left the cart unlocked while responding to an event involving a resident on the other side of the building. She acknowledged that medication carts should remain locked to prevent residents from accessing medications not prescribed to them.		