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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 05/28/2024 through 05/30/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F564, F578, F604, F656, and F761. The facility had a census of 52 and was licensed for 60 beds.	F 000		
F 564 SS=E	Inform Visitation Rghts/Equal Visitation Prvl CFR(s): 483.10(f)(4)(vi)(A)-(D) §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal	F 564		7/5/24

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

Electronically Signed | 06/12/2024

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F 564	Continued From page 1 visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: 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	F 564	* Resident #47's family member was notified on 06/14/24 that she can visit Resident #47 in the dining room. * All residents have potential to be affected by this deficient practice. * All staff were inserviced beginning on 06/13/24 by the staff development nurse regarding the facility visitation policy with clarification that families are allowed to eat in the dining room, dayroom or resident room. * Beginning 06/13/24 Three family members will be questioned about visitation each week, times 12 weeks either by phone or during a visit by the Administrator, Director of Nursing or Social Services. The results of these questions will be brought to the monthly Quality Assurance Committee meeting X 3 months beginning 07/05/24 to evaluate the effectiveness and changes will be made as deemed necessary by the Quality Assurance Committee.	

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F 564	Continued From page 2	F 564		

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.

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: Perry, Matthew R.

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		7/5/24

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F 578	Continued From page 4 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: 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.	F 578	* A copy of Resident #29's Power of Attorney(POA) was scanned into the Resident's Electronic Medical Record (EMR) on 05/30/24 by Social Services. * All Residents have potential to be affected by this deficient practice. * A 100% audit was done by Social Services on 05/31/24 on all residents with an Advanced Directive to assure all were easily accessible in the resident's EMR. The audit revealed all other POAs were uploaded in the residents EMR. The Medical Record Clerk and Social Services were inserviced on the importance of uploading Advanced Directives on all new admissions on the date of admission by the Staff Developement Nurse on 06/13/24. * The EMR on new admissions will be audited beginning 06/11/24 X 3 months,by the Resident Care Coordinator (RCC), with in 24 hours of Admission to identify if an Advanced Directive is present and uploaded into the EMR. The results of these audits will be brought to the monthly Quality Assurance Committee meeting beginning 07/05/24 X 3 months, by the RCC to evaluate the effectiveness and changes will be made as deemed necessary by the Quality Assurance Committee.	

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F 578	Continued From page 5 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.	F 578		
F 604 SS=D	Right to be Free from Physical Restraints	F 604		7/5/24

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F 604	Continued From page 6 CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: 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	F 604	* An order, medical symptom for use or monitoring for the seatbelt and consent was obtained by the Minimum Data Set(MDS) Nurse on 05/31/2024 for the use of the seat belt as a restraint on	

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F 604	Continued From page 7 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	F 604	Resident #17. A restraint assessment was done by the Registered Nurse Supervisor on 05/31/2024 and Risk and benefits were explained to the resident representative by the Registered Nurse Supervisor on 05/31/2024. * All residents requiring a restraint have potential to be affected by this deficient practice. * An inservice will be conducted by the Staff Development Nurse beginning on 06/13/24 for all Nurses and Certified Nursing Assistants. The inservice will cover the definition of a restraint and the facility's process for restraint assessment and use. *The Resident Care Coordinator will audit and observe for restraint assessment and use, twenty percent of residents once a week X 12 weeks beginning on 06/13/24. The results of these audits will be brought to the monthly Quality Assurance Committee meeting beginning 07/05/24 X 3 month and changes will be made as deemed necessary by the Quality Assurance Committee.	

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F 604	Continued From page 8 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.	F 604		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		7/5/24

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F 656	Continued From page 9 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 10 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 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.	F 656	* The Care Plan for Resident #17 was updated on 05/30/2024 to include the seat belt as a restraint by the Minimum Date Set (MDS) Nurse. * All residents have potential to be affected by this deficient practice. * An inservice will be conducted by the Staff Development Nurse beginning on 06/13/24 for Nurses and Certified Nursing assistants. The inservice will cover the definition of a restraint and the facility's process for restraint assessment and use, as well as the Care Planning Process for the restraint. *The Resident Care Coordinator will audit Care Plans beginning 06/13/24 of any resident who has a new order for a restraint to assure the Restraint has been properly Care Planned. The results of these audits will be brought to the monthly Quality Assurance Committee meeting beginning 07/05/24 X 3 months and changes will be made as deemed necessary by the Quality Assurance Committee.	

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F 656	Continued From page 11 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.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		7/5/24

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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	F 761	* The identified medications were discarded properly on 05/28/2024 and reordered as needed. * All residents have potential to be affected by this deficient practice. * A 100% audit medication rooms and medication carts was conducted by the Director of Nursing and Resident Care Coordinator on 05/30/2024 and medications were discarded as needed. The Staff Development Nurse will inservice all nurses on identifying expiration dates and proper destruction of expired medications beginning 06/13/24. * The Resident Care Coordinator and/or Director of Nursing will audit medication rooms and carts beginning 06/13/24 for expired medications monthly X 4 months The results of these audits will be brought to the monthly Quality Assurance	

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 761	Continued From page 13 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.	F 761	Committee meeting beginning 07/05/24 and changes will be made as deemed necessary by the Quality Assurance Committee.	