STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 A standard recertification survey was conducted by Healthcare Management Solutions (HMS), on behalf of the MS State Department of Health, from May 13, 2019 to May 16, 2019. The standard recertification survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid and cited deficiencies at F656, F689, F758, and F761. The facility's census on May 13, 2019 was 79 residents and the facility held a license for 80 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 §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	F 656		6/21/19

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

Electronically Signed | 06/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, observation, medical record review and interview, the facility failed to implement a care plan to meet a resident's mental needs as identified in the comprehensive assessment for one (1) of 18 sampled residents, Resident #64. Findings include: The facility policy related to care plans entitled, "Care Plans-Comprehensive," revised March 2017, indicates the facility will "develop and maintain person centered care plans with each care plan designed to enhance optimal functioning of the resident by focusing on a rehabilitative program" and "care plans are revised as changes in resident's condition dictates or resident's choices change."	F 656	Disclaimer: Bedford Care Center- Monroe Hall, LLC acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and regulations. Please accept this Plan of Correction as our credible allegation of compliance. Bedford Care Center- Monroe Hall, LLC's response to this Statement of Deficiencies does not denote aggreement with the Statment of Deficiencies, nor does it constitute an admission that any deficiency is accurage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 656	Continued From page 2 Resident #64 with a diagnosis of Bipolar II, Dementia with Behavior Disturbances, Specified Anxiety Disorders and Borderline Personality Disorder, has current physician's order for anti-depressant medication including Celexa 20 milligram (mg) once time daily, with a start date of 4/30/19, Elavil 25 mg one (1) tab at night with a start date of 4/30/19, Buspar 15 mg two (2) times daily with a start date of 1/2/19 (for anxiety), Aricept 10 mg one (1) tab at night with a start date 1/2/19 for Dementia, and Abilify 2.5 mg (antipsychotic) at night with a start date 1/2/19. The most recent comprehensive assessment for Resident #64 "Minimum Data Set (MDS)," dated 4/17/19, indicates under section (N) that Resident #64 has taken antipsychotic medication in the past seven (7) days, antianxiety medication in the past seven (7) days, Resident #64 has had no gradual dose reductions since admission and there are no contraindications for the use of these medications. On the same MDS under the section (D) for Mood indicates no examples of feeling down or depressed, feeling bad about self or no suicidal thoughts. In addition, on the same MDS under section (E) for Behavior indicates no indications of psychosis, no physical symptoms directed towards others, no verbal actions directed towards others, no rejection of care and no wandering. The care plan developed for Resident #64 from the noted comprehensive assessment above dated with a start dated of 4/17/16, and end date of 8/22/19, reveal that Resident #64 will experience "no withdrawal -decreased social interaction." Medications such as Celexa 20 mg by mouth daily (antidepressant), Elavil 25 mg by	F 656	Resident #64's chart was reviewed by the Consultant Pharmacist on 5/17/19 to ensure that the resident was on the lowest possible dose of anti-psychotic medication per the alleged deficient practice. All residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice. An inservice was conducted for the certified nursing assistants, nurses, and Social Services department on 6/18/19 by the Staff Development Nurse regarding the importance of charting resident behaviors. All care plans were reviewed by the Minimum Data Set nurse on 6/21/19 and all were in compliance. The Resident Care Coordinator will review and audit the behavior charting monthly for compliance and will provide the behavior charting documentation to the Consulting Pharmacist for her monthly review for suggestions. The behavioral charting audits conducted by the Resident Care Coordinator, Registered Nurse will be submitted at least quarterly to the Quality Assessment and Assurance Committee with the Medical Director and the Quality Assurance Performance Improvement Steering Committee for their review and any recommendations or suggestions for sustaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 656	Continued From page 3	F 656		

mouth at night (antidepressant), Abilify 2.5 mg (antipsychotic) by mouth at night and Buspar 15 mg by mouth two times a day (antianxiety) are used as interventions to improve her mood and overall behavior. Direct care staff were to document the behaviors charting record.

Review of the Resident #64's nursing notes/progress notes from October 13, 2018 to May 16, 2019 reveal no incidents or reported behaviors by professional staff for which the medications are prescribed. Moreover, on 11/11/18, the progress note read, no behavior problems observed or reported. No record of behaviors documented per the care plan.

Interview with Licensed Practical Nurse (LPN) #33 on 5/16/19 at 8:20 AM, revealed that once in a while Resident #64 has some crying, but not very often. "She is sweet to me and sometimes needs more attention."

Interview with Certified Nursing Assistant (CNA) #119 in reference to Resident #64 on 5/16/19 at 8:25 AM, revealed that "I have not worked with her in a while, but when I have, she has not had behaviors. Sometimes she is needy, and I focus on her activities of daily living (ADL's). I have to watch her to make sure she gets what she needs."

Observations of Resident #64 on 5/14/19 at 8:20 AM, 11:45 AM, and 5:06 PM, and 5/15/19 at 8:19 AM, 12:00 PM, and 2:00 PM, revealed no crying or withdrawn behaviors.

Despite the assessment period showing virtually no behaviors for Resident #64 during the assessment, progress and nursing notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 656	Continued From page 4 displaying no behavior problems, a care plan that calls for Resident #64 to enhance optimal functioning and revising care plans with changes in condition, and despite interviews and observations describing and showing no behaviors, the facility has not implemented the care plan to revise medication use per the care plan and provide optimal functioning on the lowest possible dose of anti-psychotic medication. The facility staff failed to implement the care plan as directed. Failure to provide documentation to evidence behaviors to warrant the use of the listed medications prescribed for behaviors and medical conditions. Interview with MDS/LPN #58 on 5/15/16 at 3:00 PM, verified the care plan had not been implemented related to the use of psychotropic medications at the lowest dose and staff failed to provide documentation of behavior tracking for Resident #64 to evidence the need for such medication.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, interview, and record review, the facility failed to properly assess one (1) resident's bi-lateral side rails use	F 689	Resident #37's bilateral half siderails were assessed by the Minimum Data Set Nurse on 6/19/19 and determined not to	6/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 689	Continued From page 5 as a potential accident hazard out of a survey sample of three (3) residents reviewed for accidents, Resident #37. Findings include: A facility policy entitled, "Safety and Supervision of Residents," dated as revised 7/17, documented, " . . .Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. . .The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. . ." Per the "Record of Admission" Resident #37 was admitted to the facility on 9/20/18, with a diagnosis of Alzheimer's disease. A "Plan of Care-Current" dated as initiated 9/20/18, identified Resident #37 was at risk for injuries from falls, related to cognitive impairment. A care plan for activities of daily living dated as initiated had an intervention for the use of side rails up times two (2) and to be used as an enabler for turning and repositioning. A document entitled, "Enabler-Assist Bars (Rails) Risk-Benefit Assessment [sic] 3" dated 9/20/18, found under the assessments tab in the record, dated 12/26/18, and on 3/20/19, noted the resident was non-ambulatory, had a fluctuation of consciousness, had an alteration in safety awareness, had a history of falls, and had impaired balance. Not considered a restraint. Review of the record revealed the physician orders for Resident #37 included the use of a	F 689	be a potential accident hazard per the alleged deficient practice. Resident #37's "Enabler-Assist Bars (Rails) Risk- Benefit Assessment" was updated on 6/19/19 to reflect the assessment by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An inservice was conducted on 5/28/19 and 5/30/19 by the Director of Nursing for all admitting nurses on the new "Enabler-Assist Bars (Rails) Risk- Benefit Assessment". The Minimum Data Set Coordinator will complete the "Enabler-Assist Bars (Rails) Risk- Benefit Assessment" quarterly and for any significant change in any resident's condition. All residents' "Enabler-Assist Bars (Rails) Risk- Benefit Assessment" were updated to include the assessment of siderails as a potential accident hazard. The updated assessment is also included in new resident admission assessments. The "Enabler-Assist Bars (Rails) Risk-Benefit Assessment" will be checked for completion and accuracy by the Resident Care Coordinator on the 48 hour post admission audits. The Medical Record's person will audit charts for "Enabler-Assist Bars (Rails) Risk- Benefit Assessment" completion within 72 hours of admission and at least quarterly on all residents. The audit reports will be submitted to the Quality Assessment and Assurance Committee at least quarterly for the Medical Director and Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 689	Continued From page 6 one-half side rail up times two (2) as an enabler for turning and positioning dated 9/21/18. The "Incident Care Report," dated 11/25/18, for Resident #37, identified the resident was found on the floor in her room. The notation did not identify if the resident transferred from her wheelchair to her bed or from her bed to the wheelchair. On 12/07/18 an "Incident Care Report" for Resident #37 noted the resident was found on the floor of her room. This report identified the resident attempted to get out of her wheelchair. Per review of an "Incident Care Report" dated 12/08/18, Resident #37 was found on the floor between the bed and the window. There was no information in this incident report to show if the resident's bi-lateral side rails were up or not. On 3/17/19, an "Incident Care Report" noted Resident #37 fell on the floor and was found on the side of her bed. There was no information in this report to show if the resident's bi-lateral side rails were up or not. Finally, an incident report dated 4/26/19, documented Resident #37 was found on the floor on the side of her bed. It was noted the side rails were up times two (2) during this incident. Review of the care plan for Resident #37 found interventions provided after each identified incident. The quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/20/19, noted Resident #37 was unable to complete the	F 689	Performance Improvement Steering Committee's suggestions or recommendations for sustaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 689	Continued From page 7 "Brief Interview for Mental Status (BIMS)" evaluation due to the resident being rarely/never understood. The MDS revealed the resident was assessed by staff to be moderately cognitively impaired. Resident #37 was identified to require the assistance of one staff member for bed mobility and transfers. An interview was conducted with a Certified Nursing Assistant (CNA) #42 on 5/14/19 at 4:33 PM. CNA #42 stated "the resident would attempt to get out of bed on her own." CNA #62 was interviewed on 5/15/19 at 12:27 PM, and she confirmed the resident would attempt to climb out of her when the side rails were up. Registered Nurse (RN) #66 was interviewed on 5/15/19 at 12:33 PM. RN #66 said the resident would "attempt to climb out of the bed when the side rails were up." The Physical Therapist (PT) #102 was interviewed on 5/15/19 at 1:02 PM, and stated nursing assesses for the use of side rails. An interview was conducted with the MDS Coordinator on 5/15/19 at 2:00 PM. The MDS Coordinator said the side rails were to be used to keep the resident in bed since the resident falls a great deal. She said she did not believe the side rails were considered an accident hazard. During this interview the staff member stated the resident can freely move around in her bed and there were times in which she has observed the resident completely stretched out width wise while in bed. Review of the current care plan verified updated after each incident.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 689	Continued From page 8 The Director of Nursing (DON) was interviewed on 5/06/19 at 12:29 PM. The DON stated there was no consent for the use of the side rails and there was no documentation that would evidence the risks verses benefits for the use of the side rails was discussed with the Resident #37 or a representative for Resident #37.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		6/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 758	Continued From page 9 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, observation, medical record review, and interview, the facility failed to ensure each residents drug regimen is free from unnecessary drugs for one (1) of five (5) sampled residents, Resident #64. An unnecessary drug is a drug when used without adequate indications for its use. Findings include: The facility policy related to Antipsychotic medication entitled "Antipsychotic Medication Use", revised June 2015, indicates "antipsychotic medication will be prescribed at the lowest possible dosage for the shortest period of time and subject to gradual dose reductions and re-review."	F 758	Resident # 64's chart was reviewed by the Consultant Pharmacist on 5/17/19 to ensure compliance with recommendations with gradual dose reductions and adequate indications for use for the alleged deficient practice. All residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice. An audit was completed on 6/20/19 by the Director of Nursing for all residents' medical charts to ensure that gradual dose reductions had been recommended and/or attempted unless clinically contraindicated according to the federal guidelines. The Consulting Pharmacist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 758	Continued From page 10 Review of the electronic medical record (EMR) physician order sheet revealed Resident #64 had diagnoses of Bipolar II, Dementia with Behavior Disturbances, Specified Anxiety Disorders and Borderline Personality Disorder. Resident #64 has current physician's orders, located in the EMR under physicians orders tab, for anti-depressant medication including Celexa 20 milligram (mg), (antidepressant), one (1) daily-start date of 4/30/19, Elavil 25 mg one (1) tab, (antidepressant), at night start date of 4/30/19, Buspar 15 mg, (anti-anxiety), two (2) times daily start date of 1/2/19, Aricept 10 mg one (1) tab (for dementia) at night start date 1/02/19, and Abilify 2.5 mg, (an antipsychotic), at night start date 1/2/19. Review of the annual "Minimum Data Assessment (MDS)" completed 11/14/18, documented admission to the facility 3/22/18. Review of the resident "Brief Interview for Mental Status (BIMS)" revealed 15 out of 15 to evidence Resident #64 was cognitively intact and able to make her own decisions. The assessment failed to identify any issue with mood or note any behaviors. The document identified the resident had received antipsychotic medications every day routinely with no gradual dose reduction attempted. Review of the most recent MDS, dated 4/17/19, indicates under section (N) that Resident #64 has taken antipsychotic medication in the past seven (7) days, antianxiety medication in the past seven (7) days, Resident #64 has had no gradual dose reductions since admission, (3/22/18), and there are no contraindications for the use of these	F 758	will maintain a log to include all residents receiving psychotropic medications, last gradual dose reduction attempted, and next evaluation due. An inservice was conducted by the Director of Nursing for the Resident Care Coordinator, Registered Nurse on 6/20/19 regarding the psychotropic log. The psychotropic log will be audited for compliance by the Resident Care Coordinator at least monthly after the Director of Nursing receives the Consulting Pharmacist's monthly report. If any discrepancy or concern is revealed during the audit, the Consulting Pharmacist will be notified for immediate correction by the Resident Care Coordinator or Director of Nursing. The psychotropic log and audits will be brought to the Quality Assessment and Assurance Committee by the Resident Care Coordinator at least quarterly for the Medical Director and the Quality Assurance Performance Improvement Steering Committee's suggestions or recommendations for sustaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 758	Continued From page 11	F 758		

medications. On the same MDS under the section (D) for Mood indicates no examples of feeling down or depressed, feeling bad about self or no suicidal thoughts. In addition, on the same MDS under section (E) for Behavior indicates no indications of psychosis, no physical symptoms directed towards others, no verbal actions directed towards others, no rejection of care and no wandering.

The care plan developed from the noted comprehensive assessment above dated with a start dated of 4/17/16, and end date of 8/22/19, reveal that Resident #64 will experience "no withdrawal -decreased social interaction" Medications such as Celexa, 20 mg by mouth daily, Elavil 25 mg by mouth at night, Abilify, 2.5 mg by mouth at night and Buspar 15 mg by mouth two (2) times a day are used as interventions to improve her mood and overall behavior.

Review of the Resident #64's nursing notes/progress notes from October 13, 2018 to May 16, 2019 reveal no incidents or reported behaviors by professional staff for which the medications are prescribed. Moreover, on 11/11/18, the progress note written by Licensed Practical Purse (LPN #45) read, no behavior problems observed or reported. Therefore, there were no adequate indications for the use of the medication noted above.

In addition, interview with LPN #33 on 5/16/19 at 8:20 AM, revealed that once in a while she has some crying, but not very often. "She is sweet to me and sometimes needs more attention."

Interview with CNA #119 on 5/16/19 at 8:25 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 758	Continued From page 12 revealed that "I have not worked with her in a while, but when I have, she has not had behaviors. Sometimes she is needy, and I focus on her activities of daily living (ADL's). I have to watch her to make sure she gets what she needs." In addition to the lack of progress notes on behaviors, interviews regarding the lack of behaviors, observations on 5/14/19 at 8:20 AM, 11:45 AM, and 5:06 PM, and 5/15/19 at 8:19 AM, 12:00 PM, and 2:00 PM, revealed no crying or withdrawn behavior. Interview with the Pharmacist Consultant #114 on 05/16/19 at 12:45 PM, the Consultant stated, "We have had reductions in Elavil but am not aware of the addition of Celexa as it was added after my review." The pharmacist failed to make recommendation for dose reductions or reference the use of duplicate therapy regarding the antidepressants. The pharmacist signed the monthly physician's order each month to evidence review, but did not review the record for evidence of behaviors to warrant the use of the medications to include antipsychotic, antianxiety or antidepressants. Interview with the facility physician #120 indicated, "I know what you mean. She has had no behaviors and is stable. I'm inclined to leave her medication as listed. We can meet with Pharmacy and take a look at a dose reduction."	F 758		
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	F 761		6/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 13 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 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 policy review, observation, and interview, it was determined the facility failed to ensure medical care supplies stored in one (1) of two (2) medication rooms were dated with an acceptable use by date. There were 13 culture tubes with dates that had expired past the date for safe use. This was found in one (1) of two (2) medication storage rooms. Findings include: The Director of Nursing (DON), provided a written statement that there was no formal policy available for inspection of medical care supplies	F 761	Any and all expired culture swabs were discarded on 5/15/19. All supply closets/storage areas were checked immediately for expired supplies and over-the-counter medications and are in substantial compliance. All residents have the potential to be affected by the alleged deficient practice The Central Supply Clerk was inserviced by the Staff Development nurse on 5/20/19 regarding the procedure for checking supply storage areas for expired	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 14 for expiration dates and no one was assigned the task to monitor medical care supplies. This letter was provided on 5/15/19. Inspection of the medication storage rooms on 5/15/19 at 2:00 PM, revealed 13 culture swabs that expired on 10/2018. The culture swabs were available for use in one (1) of two (2) medication rooms located on the Mockingbird unit. Interview on 5/15/19 at 2:00 PM, with the DON, revealed nurses were supposed to discard expired supplies when found. She said before obtaining a medication or items needed to perform resident care, the nurse should always check the item's expiration date to prevent use of outdated products. The DON said there is no policy specific for monitoring supplies in the facility to keep outdated supplies out of use. She did provide a statement that all supplies are checked for expiration dates upon monthly pharmacy inspections and prior to resident use. In an interview with the DON at 5/16/19 at 2:15 PM, she said the Central Supply person and the Pharmacist look for expired items, but no one is assigned to the task.	F 761	supplies and over-the-counter medications. All medication and supply storage areas will be checked monthly by the Central Supply clerk for any expired over-the-counter medications and supplies. The "Central Supply Expired Stock Log", that is posted in each medication/supply closet will be initialed by Central Supply clerk upon inspection of all areas. Any expired items will be noted in the comments section on the log and discarded immediately. The Director of Nursing will be notified accordingly. The "Central Supply Expired Stock Log" will be brought to the Quality Assessment and Assurance Committee at least quarterly for the Medical Director and the Quality Assurance Performance Improvement Steering Committee's suggestions or recommendations for sustaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/15/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	**300 CAHAL STREET** **HATTIESBURG, MS 39401**

(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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING **02 - BEDFORD CARE CENTER MONROE HALL** B. WING _____	**05/15/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	**300 CAHAL STREET** **HATTIESBURG, MS 39401**

(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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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
E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/15/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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.