

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/17/2025
NAME OF PROVIDER OR SUPPLIER  Bedford Care Center of Mendenhall		STREET ADDRESS, CITY, STATE, ZIP CODE  925 West Mangum Avenue Mendenhall, MS 39114	

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 0760  Level of Harm - Actual harm  Residents Affected - Few	Ensure that residents are free from significant medication errors.  (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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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interview, and facility policy review, the facility failed to ensure residents were free from significant medication errors by failing to accurately reconcile hospital discharge medications and ensure timely and accurate medication administration, which resulted in missed doses of prescribed antibiotic therapy and subsequent rehospitalization for wound infection and dehiscence (surgical incision that opens or pulls apart) for Resident #1 and duplicate administration of antihypertensive medications for Resident #2, affecting two (2) of four (4) sampled residents. Findings Include: Review of the facility's policy, Administering Medications revised 8/02/22, revealed, Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 3. Medications must be administered in accordance with the orders, including any required time frame. 17. The individual administering the medication must initial the resident's EMAR (Electronic Medication Administration Record) on the appropriate line after giving each medication and before administering the next resident's medication. Review of the facility's policy, Reconciliation of Medications on Admission revised 8/02/22, revealed. The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation 1. Gather the information needed to reconcile the medication list: a. Medication list from referring facility; b. Discharge summary from referring facility. e. Most recent medication administration record (MAR), if this is a readmission. General Guidelines 1. Medication reconciliation is the process of generating a master list of the resident's current medications. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. 4. Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team. Resident #1 Record review of the admission Record revealed the facility admitted Resident #1 on 7/01/22 and he had a Principal Diagnosis of Encounter for Surgical Aftercare Following Surgery on the Digestive System with an Onset Date of 11/10/2025. Record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 12/09/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated his cognition was intact. Record review of the After Visit Summary dated 12/05/25 from an acute care hospital revealed Instructions including. Your medications have changed START taking doxycycline. Prescribed Medication Information. All medication must be taken as prescribed. Contact your physician before stopping any medication. Your Medication List. Doxycycline 100 mg (milligram) capsule Take 1 capsule by mouth in the morning and 1 capsule before bedtime. Do all this for 5 days. Record review of the Medication Administration Record (MAR) for 12/01/25 through 12/31/25 for Resident #1 revealed Doxycycline was not administered until 12/08/25, which was three (3) days after his discharge from the hospital. Record review of the Medication Error Report for Resident #1, dated 12/08/25, revealed the Date of Error was 12/5/25. Further review revealed the Medication and Dosage Given was Pyridoxine (Vitamin B6) 100 mg and What is Physician's order was listed as Doxycycline 100 mg BID (two times daily) x (times) 5 days. The Reason for Medication error revealed Nurse states oversight. The Outcome to resident revealed there was a delay in treatment. The Physician response was The good thing is there is not harm from receiving Vitamin B6. Just start doxycycline. Surgical Site looks good. Record review of the Progress Notes, dated 12/9/25 revealed Resident #1 was transferred to an acute care hospital due to the surgical site noted to have dehiscence. Record review of the History and Physical, dated 12/09/25, revealed Resident #1 had wound dehiscence, with purulent drainage. On 12/17/25 at 1:45 PM, an interview with the Director of Nursing (DON) revealed that during a medication review of the medications for Resident #1 following return from hospitalization on 12/05/25 with discharge instructions that included a physician's order for Doxycycline 100 milligrams by mouth twice daily for surgical wound infection had been mistakenly entered into the resident's medical record as pyridoxine 100 milligrams by mouth twice daily by Registered Nurse #1. She confirmed he missed six (6) doses of the antibiotic therapy prescribed for infection of his abdominal surgical wound. She confirmed that on 12/09/25 the resident was hospitalized due to dehiscence of his abdominal surgical wound and was treated during his hospitalization with intravenous antibiotic therapy for infection in his surgical wound. On 12/16/25 at 1:30 PM an interview with Nurse Practitioner (NP) #1 revealed that on 12/08/25 record review of the medications for Resident #1 following return from hospitalization on 12/05/25 with discharge instructions that included a physician's order for Doxycycline for</p>		