STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255150	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Care Center of Mendenhall	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews and facility policy review the facility failed to implement comprehensive care plans for two (2) of (15) sampled Residents. Residents #14 and Resident #42.Findings include: A record review of the facility policy Comprehensive Care Plan, revised 8/24/22, revealed, Policy: It is the facility's policy to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs identified through the comprehensive assessment . A record review of the facility policy titled Safe Transfer and Lifting of Residents, revised 8/2/22, revealed, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility used appropriate techniques and devices to lift and move residents.V. c. Identifies resident/ensures proper transfer is followed per care plan. Resident #14 Record review of the Incident Investigation Summary dated 4/20/26 revealed, .The investigation identified that the CNA did not follow the resident care plan and facility policy related to transfer technique during the shifts on 4/15/26. During a phone interview on 6/23/26 at 2:02 PM, Certified Nursing Assistant (CNA) #1 stated she was assigned to Resident #14 on 4/15/26 and transferred the resident from the bed to the wheelchair using a sit to stand lift. She acknowledged the resident was supposed to be transferred with a total lift and confirmed the total lift requirement was identified on the Kardex. CNA #1 stated she knew the correct transfer method but failed to follow the Kardex and comprehensive care plan because she was exhausted. She stated the resident could halfway stand and hold onto the sit to stand lift. During a phone interview on 6/23/26 at 2:10 PM, CNA #2 stated CNA #1 asked her to assist with transferring Resident #14. She stated when she entered the room, the sit to stand lift was already in use. She stated they used the lift to complete the transfer and pull the resident's pants into place before placing the resident in the wheelchair. CNA #2 stated Resident #14 was not her assigned resident, and she did not review the Kardex prior to assisting with the transfer. She stated she had observed staff use both a total lift and a sit to stand lift with the resident. During an interview on 6/25/26 at 10:20 AM, CNA #2 stated she routinely reviews the Kardex before using a mechanical lift. She stated if a resident is new or the transfer method is unclear, she checks with the nurse or therapy staff. She further stated a sit to stand lift is appropriate only for residents (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who can partially bear weight. During an interview on 6/25/26 at 11:14 AM, the Nurse Practitioner stated Resident #14 could not consistently follow commands. She stated residents must be able to follow commands before a sit to stand lift is used and confirmed she would not recommend its use for Resident #14. During an interview on 6/25/26 at 11:54 AM, Licensed Practical Nurse (LPN) #2 stated Resident #14 had foot drop and osteoporosis. She stated the resident should not have been transferred using a sit to stand lift because of those conditions. During an interview on 6/25/26 at 1:13 PM, the Director of Nursing (DON) stated a sit to stand lift should not be used for residents who cannot bear weight or consistently follow instructions. She confirmed Resident #14 could not consistently follow commands and acknowledged there is a possibility of injury when the wrong lift is used. She further confirmed staff failed to follow the resident's care plan. A record review of Resident #14's admission Record revealed an admission date of 11/5/20 with diagnoses including Alzheimer's (Alz) disease, dementia, and disorders of bone density and structure. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/26 revealed the resident was severely cognitively impaired. Section GG indicated the resident was dependent on transfers. The assessment further revealed bilateral lower extremity range of motion impairments involving the hips, knees, ankles, and feet. A record review of Resident #14's Care Plan Report revealed .Focus: The resident has.Alz Dementia.01. Dependent using [NAME] 11 Total Lift . with a date initiated of 9/26/25. A record review of Resident #14's Kardex Report as of 4/16/26 revealed the resident was to be transferred using a total lift. A record review of the facility's Documentation Survey Report dated April 2026 revealed the resident was transferred using a total lift during the 7:00 AM to 3:00 PM shift on 4/15/26. However, staff interviews confirmed a sit to stand lift was actually used during the transfer. Resident # 42: On 06/24/26 at 7:52 AM, Licensed Practical Nurse (LPN) #1 was observed providing medication administration of gastrostomy tube medications. Prior to administration, the resident was noted to have a sign on the door indicating Enhanced Barrier Precautions (EBP). During care which involves close contact, LPN#1 did not don (put on) a gown prior to administering the medications and was observed with her uniform touching the resident's bed linens while adjusting the bed height and when looking for the resident's gastrostomy tube in the resident's linens. On 6/24/26 at 8:01 AM, during an interview LPN #1 stated that she thought gowns had to be worn for the resident's wound care or for nephrostomy tube site care, but not for medication administration. She noted that EBP would help prevent spread of germs from staff to the resident when performing care such as in this instance when her uniform came in contact with the resident's linens. On 6/24/26 at 3:08 PM, the Infection Preventionist stated nurses should utilize EBP to prevent (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contamination of a resident's indwelling medical devices by staff or from resident to resident to and failure to wear them correctly puts residents at risk. On 6/24/26 at 3:14 PM, during an interview the DON revealed gowns should be worn when performing medication administration via gastrostomy tube to avoid spreading infection to the tube site as it is an opening to the skin for contamination and failure to follow EBP can lead to the resident getting an infection. She further noted that she expects staff to follow EBP in accordance with the facility policy. A record review of Resident #42's admission Record revealed she was admitted on [DATE] with diagnoses that included cerebral infarction. A record Review of Resident #42's Order Summary Report revealed an order for Enhanced Barrier Precautions. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/12/26 revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS) due to cognitive impairment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and facility policy review, the facility failed to ensure residents were transferred using the care planned mechanical lift, resulting in Resident #14 being transferred with an inappropriate sit to stand lift rather than the required total lift for one (1) of three (3) residents who required a lift for transfers.Findings include:A record review of the facility policy titled Safe Transfer and Lifting of Residents, revised 8/2/22, revealed, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility used appropriate techniques and devices to lift and move residents.V. c. Identifies resident/ensures proper transfer is followed per care plan.Record review of the Incident Investigation Summary dated 4/20/26 revealed, .The investigation identified that the CNA did not follow the resident care plan and facility policy related to transfer technique during the shifts on 4/15/26.On 6/23/26 at 2:02 PM, during a phone interview, Certified Nursing Assistant (CNA) #1 stated she was assigned to Resident #14 on 4/15/26 and transferred the resident from the bed to the wheelchair using a sit to stand lift. She acknowledged the resident was supposed to be transferred with a total lift and confirmed the total lift requirement was identified on the Kardex. CNA #1 stated she knew the correct transfer method but failed to follow the Kardex and comprehensive care plan because she was exhausted. She stated the resident could halfway stand and hold onto the sit to stand lift.On 6/23/26 at 2:10 PM, during a phone interview, CNA #2 stated CNA #1 asked her to assist with transferring Resident #14. She stated when she entered the room, the sit to stand lift was already in use. She stated they used the lift to complete the transfer and pull the resident's pants into place before placing the resident in the wheelchair. CNA #2 stated Resident #14 was not her assigned resident, and she did not review the Kardex prior to assisting with the transfer. She stated she had observed staff use both a total lift and a sit to stand lift with the resident.On 6/25/26 at 10:20 AM, during an interview, CNA #2 stated she routinely reviews the Kardex before using a mechanical lift. She stated if a resident is new or the transfer method is unclear, she checks with the nurse or therapy staff. She further stated a sit to stand lift is appropriate only for residents who can partially bear weight.On 6/25/26 at 11:14 AM, during an interview, the Nurse Practitioner stated Resident #14 could not consistently follow commands. She stated residents must be able to follow commands before a sit to stand lift is used and confirmed she would not recommend its use for Resident #14.On 6/25/26 at 11:54 AM, during an interview, Licensed Practical Nurse (LPN) #2 stated Resident #14 had foot drop and osteoporosis. She stated the resident should not have been transferred using a sit to stand lift because of those conditions.On 6/25/26 at 1:13 PM, during an interview, the Director of Nursing stated a sit to stand lift should not be used for residents who cannot bear weight or consistently follow instructions. She confirmed Resident #14 could not consistently follow commands and acknowledged there is a possibility of injury when the wrong lift is used. She further confirmed staff failed to follow the resident's care plan.A record review of Resident #14's admission Record revealed an admission date of 11/5/20 with diagnoses including Alzheimer's (Alz) disease, dementia, and disorders of bone density and structure.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/26 revealed the resident was severely cognitively impaired. Section GG indicated the resident was dependent on transfers. The assessment further revealed bilateral lower extremity range of motion impairments involving the hips, knees, ankles, and feet.A record review of Resident #14's Care Plan Report revealed .Focus: The resident has.Alz Dementia.01. Dependent using [NAME] 11 Total Lift . with a date initiated of 9/26/25.A record review of Resident #14's Kardex Report as of 4/16/26 revealed the resident was to be transferred using a total lift.A record review of the facility's Documentation Survey Report dated April 2026 revealed the resident was transferred using a total lift during the 7:00 AM to 3:00 PM shift on 4/15/26. However, staff interviews confirmed a sit to stand lift was actually used during the transfer.