

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255328		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CENTER OF MARION				STREET ADDRESS, CITY, STATE, ZIP CODE 6434 A DALE DR , MARION, Mississippi, 39342			
(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) MS #3027311, at the facility on 6/16/26. CI MS #3027311 was investigated related to resident rights, accidents, and quality of care. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and F689 was cited. The facility held a license for 120 beds, with a census of 71.			F0000			
F0689 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 record review, interviews, and facility policy review, the facility failed to apply a shoulder restraint during transportation in the facility van for one (1) of three (3) sampled residents (Resident #1). Findings include: A review of the facility's policy "Procedure Accidents/Incident Reporting", undated, revealed, "...Accident/Incident is defined as an unexpected happening, which may or may not have caused loss or injury to a visitor, resident and/or staff person..." A review of the facility's policy "Providing Resident Transport out of Facility", dated 7/2008, revealed, "...It is the policy of this facility to arrange transportation for our residents to, out of the facility,			F0689			

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 reverse for further 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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F0689 SS = D	Continued from page 1 consultation visits..." A record review of the manufacture's guidelines "Wheelchair Tie-Downs" revealed, "...Wheelchair restraints ensure the passenger remains in a safe, forward-facing position when the vehicle is in use...The wheelchair user should also use a shoulder and lap seat belt..." A record review of the "Resident Council Meeting Minutes" dated 5/21/2026, revealed, Resident #1 was in attendance and discussed van safety with the "Person Responsible" listed as the Administrator. On 6/16/26 at 9:50 AM, an interview with the facility's State Ombudsman revealed that during the 5/21/26 Resident Council meeting, Resident #1 voiced a concern that during transportation to a physician appointment, the driver secured the wheelchair with the four-point securement system and lap belt but failed to apply the shoulder restraint. On 6/16/26 at 11:00 AM, during an interview, Resident #1 stated that when transported to a physician appointment, the transport team secured the resident's wheelchair using a four-point wheelchair securement system and applied a lap belt; however, a shoulder restraint was not applied. Resident #1 confirmed feeling unsafe during the transport and requested that the shoulder restraint be applied. Resident #1 revealed that despite the request, the transport driver did not apply the shoulder restraint. Resident #1 further revealed that the matter was later discussed with the Administrator, who informed the resident that the facility was not required to utilize both a lap belt and shoulder restraint during resident transportation. On 6/16/26 at 11:50 AM, during an interview, the Activities Director, who was responsible for transportation at the time of Resident #1's transport, revealed that during the Resident Council meeting held on 5/21/26, Resident #1 voiced concerns regarding transportation safety and reported that only a lap belt was applied during van transportation. Resident #1 expressed feeling unsafe being transported without a shoulder restraint. The Activities Director revealed that both the Ombudsman and Administrator were present during the meeting. According to the Activities Director, the Administrator explained that shoulder restraints were available and could be provided upon request; however, the facility believed it was operating in compliance with transportation requirements. The Activities Director confirmed being unaware of any			F0689			

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F0689 SS = D	Continued from page 2 other residents who had voiced concerns regarding transportation safety. The Activities Director further confirmed transporting Resident #1 to a physician appointment on 3/26/26 and securing the resident's wheelchair using the four-point securement system and lap belt; however, the shoulder restraint was not applied due to a lapse in judgment. On 6/16/26 at 1:15 PM, during an interview, the Administrator confirmed that Resident #1 was transported to a scheduled medical appointment on 3/26/2026. The Administrator revealed that the transportation driver secured the resident's wheelchair using the four-point floor securement system and applied the lap restraint; however, a shoulder restraint was not applied during the transport. The Administrator stated that transportation staff are expected to follow the manufacturer's safety guidelines when transporting residents and securing wheelchairs within the transport van. The Administrator further revealed that the manufacturer's guidelines require the use of both a lap restraint and shoulder restraint for wheelchair occupants during transport. The Administrator confirmed that transportation staff had received training on the proper use of the wheelchair securement system and occupant restraints. The Administrator acknowledged that the shoulder restraint should have been applied during Resident #1's transport and indicated that the failure to do so was an isolated occurrence and not consistent with the facility's usual transportation practices. The Administrator confirmed that he was not aware of the incident until the Resident Council meeting on 5/21/2026. A record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 9/22/2023 and had current diagnoses including Urinary Tract Infection and Anemia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/2/2026 revealed Resident#1 had a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated Resident #1's cognition was intact.	F0689			