

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255150		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CENTER OF MENDENHALL				STREET ADDRESS, CITY, STATE, ZIP CODE 925 WEST MANGUM AVENUE , MENDENHALL, Mississippi, 39114			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Compliant Investigation (CI) at the facility from 6/22/26 through 6/25/26. CI MS# 2986961 was investigated for falls from a lift and F656 and F689 were cited related to this Facility Reported Incident (FRI). During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565 and F880 were cited related to the recertification survey. The facility had a census of 57 and was licensed for 60 beds.			F0000			
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.			F0565			

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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F0565 SS = E	Continued from page 1 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to respond to Resident Council concerns and recommendations for three (3) of (3) residents interviewed. (Residents #11, #22, and #26). Findings Include: A record review of the facility policy titled, "Resident Council Meeting," with a revision date of 10/1/22, revealed, "...7. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate decisions to the Council..." At 9:25 AM on 6/23/26, during an interview, Resident #22 reported that upon admission less than a year ago, she was told that Certified Nursing Assistants (CNAs) would make her bed daily, as she is unable to do so due to chronic lower back problems. Resident #22 mentioned that despite repeated requests, staff continued to fail to make her bed. She stated, "This is my home," and she expected the facility to provide the service as promised. On 6/23/26 at 3:00 PM, during the Resident Council meeting, several residents expressed a desire for their beds to be made daily, believing CNAs were responsible for this task. They felt that having their beds made contributed to a clean, organized, and homelike environment and noted that this concern had been previously raised with staff in earlier meetings. Resident #11 reported that her bed remained unmade despite being out of it most of the day. She indicated that she had repeatedly asked staff to make her bed, but they only changed the sheets on shower days but still neglected to make the entire bed. Resident #11 shared that she made			F0565			

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F0565 SS = E	Continued from page 2 her bed daily when living at home and expected the same in the facility. Resident #26 mentioned his desire for his bed to be made every day. He stated that since staff did not routinely make his bed, he attempted to straighten it himself from his wheelchair to keep his room neat. On 6/23/26 between 3:30 PM and 5:30 PM, the State Agency made observations of randomly selected resident rooms. This revealed several residents were not present in their rooms and their beds remained unmade. On 6/24/26 between 1:00 PM and 2:30 PM, additional random observations revealed residents were not present in their rooms and several beds remained unmade. On 6/24/26 at 9:48 AM, during an interview, the Activities Director acknowledged residents raised concerns during the Resident Council meeting regarding daily bed making. The Activities Director acknowledged the concern was not documented in the Resident Council meeting minutes. On 6/24/26 at 9:52 AM, during an interview, the Administrator stated he regularly attended Resident Council meetings when invited by residents. The Administrator acknowledged residents discussed concerns regarding daily bed making during the Resident Council meeting but stated he did not consider the concern significant enough to document as a grievance. The Administrator further stated it was the responsibility of the CNAs to make residents' beds daily. On 6/25/26 at 9:09 AM, during a follow-up interview, Resident #22 stated she routinely attended Resident Council meetings where the Administrator was often present. Resident #22 stated residents had repeatedly voiced concerns regarding beds not being made but the concerns continued without resolution. A record review of the most recent Resident Council Meeting dated 6/5/26 shows no reference of concerns mentioned by any Residents who attended. A record review of Resident #22's "Admission Record" revealed an admission date of 1/9/26 with diagnoses including Unspecified Cirrhosis of the Liver. A review of Resident #22's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/26 revealed a Brief Interview for Mental Status (BIMS) score of 9.			F0565			

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F0565 SS = E	Continued from page 3 A review of Resident #26's "Admission Record" revealed an admission date of 7/8/25 with diagnoses including Chronic Respiratory Failure. A review of Resident #26's MDS with an ARD of 4/14/26 revealed a BIMS score of 14, indicating the resident was cognitively intact. A review of Resident #11's "Admission Record" revealed an admission date of 11/13/25 with diagnoses including anxiety disorder. A review of Resident #11's MDS with an ARD of 5/19/26 revealed a BIMS score of 11, indicating the resident had moderate cognitive impairment.	F0565					
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880					

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F0880 SS = E	Continued from page 4 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to implement an effective infection prevention and control program for two (2) of three (3) residents observed for infection prevention practices related to medication administration and wound care. (Residents #4 and #42). Findings Include: Record review of the facility policy "Handwashing/Hand Hygiene" revised 8/2/22	F0880					

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F0880 SS = E	Continued from page 5 revealed, "This facility considers hand hygiene the primary means to prevent the spread of infection and recommends to perform hand hygiene after removing gloves..." Record review of the facility policy "Enhanced Barrier Precautions" revised 3/27/26 revealed, "Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms..." Resident #4 During an observation of wound care at 2:30 PM on 6/24/26 provided by Registered Nurse (RN) #1 revealed the nurse cleansed the dirty sacral wound with normal saline soaked gauze, changed gloves, then cleansed with genta violet compound, applied clean gloves and applied silver collagen and dressing. She then discarded her gloves and applied a clean pair before performing wound care on the resident's left gluteal wound site. During care, she did not perform hand hygiene between glove changes or before starting care on the second wound. In an interview at 2:43 PM on 6/24/26, RN #1, noted that hand hygiene should be performed any time gloves are removed to cleanse any contaminants that reached the hands through the gloves. She noted that cross contamination was possible when not performing hand hygiene particularly between care provided on multiple wounds and noted that consequences include increased risk for infection of the resident's wound. An interview at 3:08 PM on 6/24/26, with the Infection Preventionist revealed nurses should perform hand hygiene any time gloves are removed during care to prevent spreading infection to a wound and again prior to moving from care of one wound to another to avoid spreading bacteria in one wound bed to another. She further explained that failure to do so could increase the risk of wound infection for the resident. An interview with the Director of Nursing (DON) at 3:14 PM on 6/24/26, revealed the nurse should have cleansed her hands between each glove change and before performing a second wound change because glove changes do not negate the need to clean hands to remove possible contaminants from them. She confirmed that by not doing so can increase risk for wound infection. She also stated that her expectation of staff is that they will wash hands in appropriately as instructed by facility policy.			F0880			

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F0880 SS = E	Continued from page 6 A record review of Resident # 4's "Admission Record "revealed that she was admitted on 4/16/21 with diagnoses that included Alzheimer's. A record review of Resident # 4's Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 5/5/26 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment. A record review of the resident's "Order Summary Report" with active orders as of 6/24/26 revealed an order dated 6/24/26, "Cleanse stage III Pressure Ulcer to left gluteal fold daily and as needed with normal saline or wound cleanser pat dry apply gentian violet to peri wound apply silver collagen to wound bed, secure with dry dressing..." Resident # 42: On 06/24/2026 at 7:52AM, Licensed Practical Nurse (LPN) #1 was observed performing 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 apply a gown prior to administering drugs and was observed with her scrubs 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. At 8:01 AM. on 6/24/26, LPN #1 was interviewed and when asked about EBP. She stated that she thought they 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 scrubs came in contact with the resident's linens. An Interview at 3:08 PM, on 6/24/26, with the facility's Infection Preventionist stated nurses should utilize EBP to prevent 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. An interview with the DON at 3:14 on 6/24/26, 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			F0880			

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F0880 SS = E	Continued from page 7 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 5/12/26 with diagnoses that included cerebral infarction. A record Review of Resident #42's "Order Summary Report" revealed an order dated 4/15/26 for Enhanced Barrier Precautions. A record review of the MDS with an ARD of 4/20/26 revealed the resident had a BIMS score of 07 which indicated severe cognitive impairment.	F0880					
F0656 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 §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	F0656					

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F0656 SS = D	Continued from page 8 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- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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	F0656			

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F0656 SS = D	Continued from page 9 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 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,			F0656			

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F0656 SS = D	Continued from page 10 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 Vander 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 contamination of a resident's indwelling medical			F0656			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255150		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2026	
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CENTER OF MENDENHALL				STREET ADDRESS, CITY, STATE, ZIP CODE 925 WEST MANGUM AVENUE , MENDENHALL, Mississippi, 39114			
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F0656 SS = D	Continued from page 11 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 5/12/26 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.			F0656			
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 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,			F0689			

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F0689 SS = D	Continued from page 12 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			F0689			

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F0689 SS = D	Continued from page 13 #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 Vander 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.			F0689			