

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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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M0000	Initial Comments		M0000				
M0640	The State Agency (SA) conducted an annual re-licensure survey at the facility from 6/22/26 to 6/25/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M640 and M1570. 45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, 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		M0640				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0640	Continued from page 1 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			M0640			

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M0640	Continued from page 2 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.	M0640					
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of	M1570					

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M1570	Continued from page 3 practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy 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 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			M1570			

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M1570	Continued from page 4 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. 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	M1570					

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M1570	Continued from page 5 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 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 MDS with an ARD of 4/20/26 revealed the resident had a BIMS score of 07 which indicated severe cognitive impairment.	M1570					