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	12/17/2025

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 #1Record 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 (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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F 0760 Level of Harm - Actual harm Residents Affected - Few	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 surgical wound infection had been mistakenly entered into the resident's medical record as pyridoxine. She confirmed that the resident missed six doses of Doxycycline. She confirmed that on 12/09/25 the resident was hospitalized due to dehiscence of his abdominal surgical wound. She confirmed that wound infection could result in dehiscence, the partial separation of edges resulting in reopening of a wound exposing underlying tissues.Resident #2Record review of the admission Record revealed the facility admitted Resident #2 on 9/15/22 and he had diagnoses including Hypertension. Record review of the Quarterly MDS with an ARD of 11/06/25 revealed Resident #2 had a BIMS score of 9, which indicated his cognition was moderately impaired. Record review of the Order Summary Report revealed Resident #2 had a Physician's Order, dated 6/30/24, for Lisinopril Tablet 10 mg Give 1 tablet by mouth one time a day. and an order dated 6/30/24 for Metoprolol Tartrate Tablet 50 MG 1 tablet by mouth two times a day. Record review of the Progress Notes for Resident #2 revealed a note, dated 12/10/25, for .A MIS-DOSING OF AM MEDICATIONS THIS AM WHERE RESIDENT RECEIVED HIS MEDICATIONS BY TWO DIFFERENT NURSES TWICE.Record review of the High Risk Event-Investigation Statement, dated 12/10/25, revealed Licensed Practical Nurse (LPN) #3 administered medications to Resident #2 at approximately 11:45 AM on 12/10/25 and later discovered that LPN #1 had already administered the medications to Resident #2 at approximately 9:45 AM, which indicated that the resident received twice the physician ordered dosage of Lisinopril and Metoprolol, which are antihypertensives. Record review of the Medication Error Report dated 12/10/25 for Resident #2 revealed the Date of Error was 12/10/25 and the Reason for Medication error revealed Assigned nurse not allowed to care for resident so nurse on a different hall took over and failed to sign eMAR that meds were given at 9:45 (AM). On 12/16/25 at 1:30 PM, during an interview, NP #1 stated that she had been concerned about the wrong (double) dose of Resident #2's blood pressure medications, Lisinopril and Metoprolol, being administered on the morning of 12/10/25 because the error could have caused a dangerous decrease of the resident's blood pressure. She stated that she ordered close monitoring of the resident and his vital signs for the four hours following notification by nursing staff that the resident had been given his antihypertensive medications twice. She stated that Resident (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	#2's physician was notified of the medication error and ordered intravenous fluids, which were administered at the facility.On 12/16/25 at 3:10 PM during an interview with LPN #1 she stated that LPN #2 came to the dining room and told her that LPN #3 had administered the medications scheduled for Resident #2 for 8:00 AM a second time. She explained that due to family request, LPN #2 was not allowed to administer Resident #2's medications. LPN #1 reported that at approximately 9:45 AM LPN #2 asked if she was going to give Resident #2 his medications, and she used LPN #2's laptop which was already signed in to the Electronic Medication Administration Record (EMAR) in the healthcare software, on the laptop on the top of the medication cart and prepared Resident #2's 0800 medications and administered them to him. LPN #1 stated that after all residents had their medications administered, she went to sign in on her own laptop to sign medications as administered to Resident #2 but was called away due to an emergent situation involving a different resident and forgot to sign the medications administered to Resident #2. She acknowledged that correct procedure included signing the EMAR for each resident following medication administration. She correctly identified the five rights of medication administration, including Right Dose and that the resident had not received the right dose of multiple medications including antihypertensive medications. She stated that LPN #2 was standing by the medication cart as she prepared the medications for Resident #2. She stated she was in the dining room at about 11:45 AM and LPN #2 came to the dining room and told her that LPN #3 had administered the medications scheduled for Resident #2 for 8:00 AM a second time. She reported that she assisted with monitoring Resident #2 on 12/10/25 and he had not had adverse effects related to having received the wrong dose.On 12/17/25 at 11:06 a telephone with LPN #2 revealed that she reported that she was on duty on 12/10/25 assigned to a group of residents on the 300 Hall. She stated that due to family request she was not allowed to administer medications to Resident #2, therefore, another nurse was required to administer the resident's medications. She stated that she was at her medication cart and LPN #1 used her laptop which she had logged into with her credentials to access Resident #2's EMAR to prepare and administer the medications scheduled for 8:00 AM for Resident #2 at approximately 9:45 AM. She stated that later, on the morning of 12/10/25 she had walked into a resident's room due to an emergency need and forgot to lock her cart. She stated that LPN #3, having noted on Resident #2's MAR that his medications scheduled for 8:00 AM had not been documented as administered, prepared the medications and administered medications to Resident #2 a second time at approximately 11:45 AM. She stated that this failed to ensure one of the five (5) Medication Rights, the right dose, because the resident received double the prescribed dosage, which included his medications for high blood pressure. On 12/17/25 at 3:00 PM during an interview the DON reported that she was notified by LPN #3 at approximately 11:45 AM on 12/10/25 Resident #2 received his hypertensive medications, Lisinopril and Metoprolol, twice, resulting in the resident receiving twice the physician prescribed dosage. She stated that an incident report was completed, and she conducted an investigation, Root Cause Analysis and Plan of Correction and notified the NP, primary physician and Responsible Party (RP) for Resident #2. She stated that the resident's physician ordered monitoring and IV fluids for Resident #2 because of the incident. She stated that there was no noted adverse effect noted.