STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255149	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PETAL	**908 S GEORGE STREET , PETAL, Mississippi, 39465**

(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 #504354, at the facility from 11/24/25 through 11/25/25. MS #504354 was a facility reported incident (FRI) investigated for abuse and resident rights. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550. Based on the facility's implementation of corrective Actions on 6/26/25, the SA determined the deficiency to be Past Non-Compliance (PNC) and corrected as of 6/27/25, prior to the SA's entrance on 11/24/25. The facility held a license for 60 beds, with a census of 57.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	"Past Noncompliance - no plan of correction required"	

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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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be treated with dignity and to retain personal belongings when a Certified Nursing Assistant (CNA) removed a resident's personal cellphone against her wishes for one (1) of three (3) sampled residents, Resident #1. Findings include: A review of the facility's policy, "Promoting Maintaining Resident Dignity – Resident Rights, dated 10/2/2022, revealed "…It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner…that maintains or enhances the resident's quality of life by recognizing each resident's individuality…Compliance Guidelines…11. Respect the resident's…personal possessions. Staff will not search a resident's…personal possessions without consent from the resident…" A record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/3/25 with diagnoses including Epilepsy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. A record review of the "Investigative Summary – Final	F0550		

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F0550 SS = D	Continued from page 2 Report", with "Date of Incident: 6/25/25" revealed "Investigation Findings" as interviews were conducted with staff members, resident's roommate, and resident and CNA stated that resident was taking pictures of her. CNA states she asked the resident for the phone and the resident gave it to her, where she went on to delete about ten photos of herself from the resident's phone. The resident states that she did not willingly give the CNA her phone. The Administrator came to the facility immediately and sent the CNA home and the resident's phone was returned to her, after the CNA had left it on a nurse's medication cart. Resident was interviewed that night and monitored for any signs of psychosocial harm. A full body audit was conducted that night and the Nurse Practitioner also conducted a full body audit on the next day. The resident denied taking any photos or recordings and the resident's representative went through the deleted photos with the Administrator present and there were no videos containing staff. Staff education and ins-services started on that night to include the topics of Abuse, Neglect, De-escalation and Misappropriation of Property. The "Conclusion" included that upon investigation, it was determined that this CNA exhibited inappropriate behavior and is not allowed to return to facility. A record review of a signed document provided by the Administrator, dated 11/25/25, revealed that the facility sent the employee in question home immediately, the resident's cell phone was returned to her, and she was assessed for bodily and psychosocial harm. Interviews were conducted and the family was notified. The incident was reported to the appropriate authorities. Staff in-services were started on Abuse, Neglect, and Misappropriation. On 6/26/25, and Emergency Quality Assurance meeting was held, with the Medical Director, to discuss interventions which included 100% of staff to be in-serviced before returning to work. The resident was assessed for psychosocial needs, and the employee was not allowed to return to the facility and the Agency was notified. On 11/24/25 at 7:20 PM, during an interview with Resident #1, she stated that on 6/25/25 CNA #1 entered her room, spoke to her in a demeaning manner. Resident #1 stated she pretended to record the CNA with her cellphone, after which CNA #1 demanded she surrender the phone. Resident #1 stated she refused, and CNA #1 took the phone from her and placed it on the Licensed Practical Nurse (LPN) medication cart. Resident #1 stated she did not voluntarily give up her phone and that she was later told CNA #1 was terminated.	F0550		

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F0550 SS = D	Continued from page 3 On 11/24/25 at 7:40 PM, during an interview with the Administrator, she stated CNA #1 reported taking the phone from the resident because the resident had attempted to record her. The Administrator stated the resident's family reviewed the device and did not find deleted photos. She stated CNA #1 was an agency nurse and she has not worked since she was told to leave the facility. On 11/24/25 at 7:51 PM, during an interview with CNA #2, she stated CNA #1 told her that Resident #1 had threatened to get her fired and was taking pictures of her. CNA #2 stated CNA #1 admitted to taking the resident's phone. CNA #2 told CNA #1 she needed to report the incident to the nurse because "you can't take a resident's property," stating it was a dignity concern. On 11/24/25 at 7:55 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated CNA #1 placed Resident #1's cellphone on her medication cart and told LPN #1 she had taken it because Resident #1 was filming her. LPN #1 returned the phone to the resident. LPN #1 stated Resident #1 reported CNA #1 "got on top of her" and took the phone forcefully. On 11/25/25 at 1:11 PM, during an interview with CNA #1, she denied forcefully taking the phone and stated the resident was "being combative" and filming her. CNA #1 stated that she could not remember everything that occurred. CNA #1 stated she picked up the phone and deleted photos before giving it to LPN #1. Based on the facility's implementation of corrective actions completed on 6/26/25, the SA determined the deficiency to be Past Non-Compliance (PNC) and corrected as of 6/27/25, prior to the SA's entrance 11/24/25. Validation: The SA validated on 11/25/25 through interview and record review, that all corrective actions had been completed on 6/26/25 and the deficiency removed on 6/27/25, prior to the SA's entrance on 11/24/25.	F0550		