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 **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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500. 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.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical	M0500		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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M0500	Continued from page 1 record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use	M0500		

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M0500	Continued from page 2 and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in	M0500		

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M0500	Continued from page 3 the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE 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 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	M0500		

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M0500	Continued from page 4 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. 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	M0500		

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M0500	Continued from page 5 #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.	M0500		