

|                                                                           |                                                                                                                                                                                                                                                                                   |                                                                        |  |                                                                                                        |                                                                                                                          |                                                 |                            |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>              |                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>255158</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02</b> - <b>BUILDING 02</b><br>B. WING                    |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>BEDFORD CARE CENTER OF HATTIESBURG</b> |                                                                                                                                                                                                                                                                                   |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>10 MEDICAL BOULEVARD , HATTIESBURG, Mississippi, 39401</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                      |                                                                        |  | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| K0000<br><br>Bldg. 02                                                     | <p>INITIAL COMMENTS</p> <p>42 CFR 483.09</p> <p>The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).</p> <p>There were no LSC deficiencies cited during this survey.</p> |                                                                        |  | K0000                                                                                                  |                                                                                                                          |                                                 |                            |

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 |
|-----------------------------------------------------------------------|-------|-----------|

|                                                                           |                                                                                                                                                                                                                                   |                                                                        |  |                                                                                                        |                                                                                                                          |                                                 |                            |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>              |                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>255158</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                   |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>03/03/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>BEDFORD CARE CENTER OF HATTIESBURG</b> |                                                                                                                                                                                                                                   |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>10 MEDICAL BOULEVARD , HATTIESBURG, Mississippi, 39401</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                      |                                                                        |  | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| E0000                                                                     | Initial Comments<br><br>*EMERGENCY PREPAREDNESS* Survey conducted on<br>03/04/26 revealed the above facility meets all<br>applicable Federal, State and local emergency<br>preparedness requirements. No deficiencies were cited. |                                                                        |  | E0000                                                                                                  |                                                                                                                          |                                                 |                            |

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 |
|-----------------------------------------------------------------------|-------|-----------|