| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255158 | A. BUILDING _____ B. WING _____ | C 10/15/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BEDFORD CARE CENTER OF HATTIESBURG** | **10 MEDICAL BOULEVARD HATTIESBURG, MS 39401** |

| (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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control Survey along with a complaint investigation (CI #17130, CI #16846, CI #16868, CI #16799) was conducted by the State Agency (SA) on 10/15/20. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census was 65 with facility license for 100<br><br>CI MS #16799<br>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to No Pressure Sore Precaution and Resident Neglect related to Pressure Sore.<br><br>CI MS #16846<br>The result of the investigation was unsubstantiated with no deficiencies cited for Resident Neglect related to Assess/Monitor.<br><br>CI MS #16868<br>The result of the investigation was unsubstantiated with no deficiencies cited for Resident Neglect related to Assess/Monitor.<br><br>CI MS #17130<br>The result of the investigation was unsubstantiated with no deficiencies cited for Resident Neglect and Quality of Care related to Resident Not Groomed Adequately, Facility Staffing, and Resident Safety/Falls. | F 000 | | |

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

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.