MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18CP	A. BUILDING: _____ B. WING _____	C 12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PETAL	**908 S GEORGE STREET PETAL, MS 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) COMPLETE DATE
M 000	Initial Comments On 12/28/21 through 12/29/21 State Agency conducted a complaint survey for one (1) complaint, CI MS #18402 related to Resident Abuse. Based on observations, policy reviews, record reviews and interviews the State Agency (SA) determined there was no evidence of abuse by staff. The facility employed staff after appropriate background checks which would have disqualified them for employment and were licensed by the SA. The Facility developed and implemented written policies and procedures to prohibit and prevent abuse. The facility provided in-service training for nurse aides to prevent resident abuse and ensure reporting of suspected allegations within mandated timeframes. The facility conducted a thorough investigation and reported the allegation in a timely manner after being made aware of the allegation by the local hospital social worker. The facility took measures to prevent further potential abuse. The SA cited no deficiencies. The SA found the facility to be in compliance with the Minimum Standards fot the Institutions for the care of the Aged or Infirm. Complaint CI MS #18402 was unsubstantiated.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE