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
	MS38BM	A. BUILDING: _____ B. WING _____	C 11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(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 The State Agency (SA) conducted an Abbreviated/Partial survey investigating CI MS# 16264, beginning 11/04/19 ending 11/05/19. Concerns identified in the complaint were related to abuse/fall not reported. Based on record reviews of the Care Plan, Incident Report, Medical Records, Nurses Notes, interviews with staff (Administrator, RN, Director of Nurses, LPN, and CNA), and daughter of resident, SA was unable to determine that there was deficient practice by the facility; therefore no citations will be issued for this complaint . The facility took steps to correct the problem by reporting the incident to the Miss Department of Health, and The Attorney General's Office and terminate the nurses assistant who failed to report the fall of the resident to the nurse. The census at the time of the survey was 115, with a total bed count of 120.	M 000		

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