

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51CR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/17/2019
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CENTER OF NEWTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1009 SOUTH MAIN STREET NEWTON, MS 39345		
(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 Survey Agency (SA) conducted a complaint investigation (CI MS# 16299 & CI MS# 16300) on 10/17/19. The result of the investigation was unsubstantiated for Quality of Care and Employee to Resident Abuse, with no deficiencies cited. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. The facility census on 10/16/2019 was 113.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE