

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255149		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/31/2019	
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CENTER OF PETAL				STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 000	INITIAL COMMENTS CI MS 16489 The State Agency (SA) conducted a complaint investigation on 12/31/19. Concerns identified in the complaint were related to possible quality of care. Specific concerns included: 1) Served food resident was allergic to, 2) Staff did not put compression hoses on resident, 3) Resident was extremely unclean, even with dirty fingernails, 4) Family was never informed of any changes i.e., new med's, blood in urine, visits with nurse practitioner, decrease in strength, 5) Resident did not receive therapy when she was quarantined for shingles. The result of the investigation was unsubstantiated with no deficiencies. The SA determined the facility was in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had is licensed for 60 and has a census of 54 at the time of the complaint survey.			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.