STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255149	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Care Center of Petal	908 S George Street Petal, MS 39465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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.

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be treated with dignity and to retain personal belongings when a Certified Nursing Assistant (CNA) removed a resident's personal cellphone against her wishes for one (1) of three (3) sampled residents, Resident #1.Findings include:A review of the facility's policy, Promoting Maintaining Resident Dignity - Resident Rights, dated 10/2/2022, revealed .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner. that maintains or enhances the resident's quality of life by recognizing each resident's individuality. Compliance Guidelines.11. Respect the resident's.personal possessions. Staff will not search a resident's. personal possessions without consent from the resident.A record review of the admission Record revealed the facility admitted Resident #1 on 6/3/25 with diagnoses including Epilepsy.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.A record review of the Investigative Summary - Final Report, with Date of Incident: 6/25/25 revealed Investigation Findings as interviews were conducted with staff members, resident's roommate, and resident and CNA stated that resident was taking pictures of her. CNA states she asked the resident for the phone and the resident gave it to her, where she went on to delete about ten photos of herself from the resident's phone. The resident states that she did not willingly give the CNA her phone. The Administrator came to the facility immediately and sent the CNA home and the resident's phone was returned to her, after the CNA had left it on a nurse's medication cart. Resident was interviewed that night and monitored for any signs of psychosocial harm. A full body audit was conducted that night and the Nurse Practitioner also conducted a full body audit on the next day. The resident denied taking any photos or recordings and the resident's representative went through the deleted photos with the Administrator present and there were no videos containing staff. Staff education and ins-services started on that night to include the topics of Abuse, Neglect, De-escalation and Misappropriation of Property. The Conclusion included that upon investigation, it was determined that this CNA exhibited inappropriate behavior and is not allowed to return to facility.A record review of a signed document provided by the Administrator, dated 11/25/25, revealed that the facility sent the employee in question home immediately, the resident's cell phone was returned to her, and she was assessed for bodily and psychosocial harm. Interviews were conducted and the family was notified. The incident was reported to the appropriate authorities. Staff in-services were started on Abuse, Neglect, and Misappropriation. On 6/26/25, and Emergency Quality Assurance meeting was held, with the Medical Director, to discuss interventions which included 100% of staff to be in-serviced before returning to work. The resident was assessed for psychosocial needs, and the employee was not allowed to return to the facility and the Agency was notified.On 11/24/25 at 7:20 PM, during an interview with Resident #1, she stated that on 6/25/25 CNA #1 entered her room, spoke to her in a demeaning manner. Resident #1 stated she pretended to record the CNA with her cellphone, after which CNA #1 demanded she surrender the phone. Resident #1 stated she refused, and CNA #1 took the phone from her and placed it on the Licensed Practical Nurse (LPN) medication cart. Resident #1 stated she did not voluntarily give up her phone and that she was later told CNA #1 was terminated.On 11/24/25 at 7:40 PM, during an interview with the Administrator, she stated CNA #1 reported taking the phone from the resident because the resident had attempted to record her. The Administrator stated the resident's family reviewed the device and did not find deleted photos. She stated CNA #1 was an agency nurse and she has not worked since she was told to leave the facility.On 11/24/25 at 7:51 PM, during an interview with CNA #2, she stated CNA #1 told her that Resident #1 had threatened to get her fired and was taking pictures of her. CNA #2 stated CNA #1 admitted to taking the resident's phone. CNA #2 told CNA #1 she needed to report the incident to the nurse because you can't take a resident's property, stating it was a dignity concern.On 11/24/25 at 7:55 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated CNA #1 placed Resident #1's cellphone on her medication cart and told LPN #1 she had taken it because Resident #1 was filming her. LPN #1 returned the phone to the resident. LPN #1 stated Resident #1 reported CNA #1 got on top of her and took the phone forcefully.On 11/25/25 at 1:11 PM, during an interview with CNA #1, she denied forcefully taking the phone and stated the resident was being combative and filming her. CNA #1 stated that she could not remember everything that occurred. CNA #1 stated she picked up the phone and deleted photos before giving it to LPN #1. Based on