

Mississippi State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>08/11/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BEDFORD CARE CENTER OF NEWTON</b> |                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                       |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1009 SOUTH MAIN STREET , NEWTON, Mississippi, 39345</b> |                                                                                                                          |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                           |                                                       |  | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                     | (X5)<br>COMPLETION<br>DATE |
| M0000                                                                    | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI), MS #3072073, at the facility on 8/11/16. MS #3072073 was investigated related to quality of care and infection control. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. There were no deficiencies cited. |                                                       |  | M0000                                                                                                   |                                                                                                                          |                                                     |                            |

Office of Primary Care and Health Systems Management

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