

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 57SE	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/29/2021
NAME OF PROVIDER OR SUPPLIER MCCOMB NURSING AND REHABILITATION CENTER I		STREET ADDRESS, CITY, STATE, ZIP CODE 415 MARION AVE MCCOMB, MS 39648		
(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 a complaint investigation for complaints CI MS# 17475 and CI MS# 17510 at the facility from 6/28/2021 to 6/29/2021. The SA did not substantiate the complaint for quality of care or unqualified personnel. During the complaint investigation, the SA determined that the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE