MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71IH	A. BUILDING: _____ B. WING _____	C 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO COMM LIVING CENTER	1410 WEST QUITMAN STREET IUKA, MS 38852

(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 an on site complaint investigation on 07/12/21-07/13/21 for Complaint Investigation (CI) MS #17855, for facility limiting and denying residents visitation and CI MS #17877, for alleged neglect, quality of care, and quality of life. The SA did not substantiate CI MS #17877, but substantiated CI# 17855 for federal regulations. The SA determined that the facility was in complaince with the Aged and Infirmed. The facility had a resident census of 70 and was licensed for 73 beds.	M 000		

Mississippi State Department of Health

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

Electronically Signed | 07/28/21