

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/24/2024
NAME OF PROVIDER OR SUPPLIER WOODLANDS REHABILITATION AND HEALTHCARE (		STREET ADDRESS, CITY, STATE, ZIP CODE 102 WOODCHASE PARK DRIVE CLINTON, MS 39056		
(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 follow-up revisit at the facility on 6/24/24 for the Annual Recertification that was conducted from 4/9/24 through 4/11/24. The SA found the facility had completed the required measures to place the facility back in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements effective 06/19/24; however, the facility remains out of compliance due to deficiencies cited on the 06/06/24 survey.	{M 000}		

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

TITLE

(X6) DATE

Electronically Signed

07/15/24