

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/15/2024
NAME OF PROVIDER OR SUPPLIER CHOCTAW RESIDENTIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350		
(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 On 08/15/24 the State Agency (SA) conducted an onsite complaint investigation, (CI) MS #25131 related to neglect and determined that the facility was in compliance with the Rules and Regulations for the Aged and Infirmed and no deficiencies were cited. The facility was licensed for 120 beds and the resident census was 100.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/21/24