

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>54NP</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/26/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SARDIS COMMUNITY NH</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>613 EAST LEE STREET</b><br><b>SARDIS, MS 38666</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 APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                          | <p>Initial Comments</p> <p>The State Agency (SA) conducted a complaint investigation (CI) MS# 26661 at the facility on 11/26/24. During the survey the SA determined that the facility was in compliance with the Minimal Standards of Operation for Institutions for the Aged or Infirm. The SA investigated allegations related to resident rights and there were no deficiencies cited.</p> <p>The census at the time of the complaint investigation was 53 and they held a license for 60 beds.</p> | M 000                                                                                          |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/02/24