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 |
|---|---|---|---|
| | 69SC | A. BUILDING: _____ B. WING _____ | C 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENATOBIA HEALTHCARE & REHAB | 402 GETWELL DR SENATOBIA, MS 38668 |

| (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<br><br>The State Agency (SA) conducted three (3) complaint investigations (CI MS# 26767, CI MS #26778, and CI MS #27190) at the facility on 12/11/24. 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 CI MS #26767, #26778 and #27190 related to resident rights and there were no deficiencies cited.<br><br>The census at the time of the complaint investigation was 93 and they held a license for 106 beds. | M 000 | | |

Mississippi State Department of Health

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

Electronically Signed | 12/18/24