

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36GR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2021
NAME OF PROVIDER OR SUPPLIER OXFORD HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 BELK BOULEVARD OXFORD, MS 38655		
(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 complaint surveys CI MS #17955 and CI MS #17956, from 8/9/2021 to 8/13/2021. The SA determined during the survey the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The complaints were substantiated for insufficient staffing.	M 000		

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

TITLE

(X6) DATE