

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/03/2025	
NAME OF PROVIDER OR SUPPLIER OXFORD HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1301 BELK BOULEVARD , OXFORD, Mississippi, 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) COMPLETION DATE	
M0000	Initial Comments On 11/3/25 the State Agency (SA) conducted an onsite revisit for the complaint survey completed on 10/1/25-10/2/15. The information reviewed confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 10/23/25. The facility had a census of 99 with a license for 120 beds.		M0000			11/05/2025	

Office of Primary Care and Health Systems Management

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