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
	71IH	A. BUILDING: _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO COMM LIVING CENTER	1410 WEST QUITMAN STREET IUKA, MS 38852

(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 State Initial Comments: The State Agency (SA) conducted an annual survey at the facility along with complaint investigations (CI) MS00017174 related to abuse, MS00017392 related to staffing, MS00017721 related to quality of care and treatment, resident rights, and dietary services, MS00017455 related to physical environment, and MS00017500 related to resident rights on 04/27/21 through 04/29/21. During the survey, the SA determined that the facility was in compliance with The Aged and Infirmed and found that the complaints were not substantiated. Census at time of the survey was 68 with a bed capacity of 73.	M 000		

Mississippi State Department of Health

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