

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>30CD</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/23/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SINGING RIVER HEALTH AND REHABILITATION CEN</b> |                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3401 MAIN STREET</b><br><b>MOSS POINT, MS 39563</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                                                                                  | Initial Comments<br><br>The State Agency (SA) conducted a Complaint survey, CI #17901 from 7/21/2021 to 7/23/2021. The SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. There were no deficiencies cited by the SA. | M 000                                                                                           |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE