

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>25MH</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>08/26/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MAGNOLIA SENIOR CARE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3701 PETER QUINN DRIVE</b><br><b>JACKSON, MS 39213</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                                                                | <p>Initial Comments</p> <p>A COVID-19 Focused Infection Control Survey with Complaint Investigation (CI MS #17427 and CI MS #16647), was conducted by State Agency (SA) on 8/25/21 through 8/26/21. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to for COVID-19. CI MS #17427 was unsubstantiated for missappropriation of property/injury and CI MS #16647 was unsubstantiated for neglect/accidents.</p> <p>At the time of survey, the facility had a census of 47 and was licensed for 60 beds.</p> | M 000                                                                                              |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE