| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255207 | A. BUILDING _____ B. WING _____ | C 04/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PLAZA COMMUNITY LIVING CENTER** | **4403 HOSPITAL ROAD PASCAGOULA, MS 39581** |

| (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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The State Survey Agency (SA) conducted a complaint investigation (CI MS #17629, CI MS #17715, CI MS #17765) from 4/28/21 to 4/29/21. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. The facility held a license for 120 beds, with a census of 91.<br><br>CI MS #17629<br>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Responsible Party Not Notified of Change, Resident Safety, Injury of Unknown Origin, and Neglect. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.<br><br>CI MS #17715<br>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Client Services not Performed Per Physicians Orders and Physical Environment. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.<br><br>CI MS #17765<br>The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to No Pressure Sore Precaution. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation. | F 000 | | |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.