

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>50CH</b>                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/24/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CHOCTAW RESIDENTIAL CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>135 RESIDENTIAL CENTER RD</b><br><b>CHOCTAW, MS 39350</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>A follow up survey was conducted by the State Agency (SA) on 6/23/21-6/24/21. F600, F677, F880, M500 and M610 were the deficiencies cited during an Annual survey. The facility was found to be back in compliance effective 6/21/21 with the State Licensure regulations. The facility is licensed for 120 beds and had a census of 86 during the followup. | {M 000}                                                                                               |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE