

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35KC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/23/2021
NAME OF PROVIDER OR SUPPLIER MS CARE CENTER OF DEKALB		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WILLOW AVENUE DE KALB, MS 39328		
(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 CI MS #17030 The State Agency conducted complaint investigation (CI) MS #17030 on 03/23/2021. The SA determined that the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA determined CI MS #17030 was unsubstantiated for neglect and quality of care/treatment. No deficiencies were cited. The census at the time of the survey was 49 and the facility was licensed for 60 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE