

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>71IH</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>08/04/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TISHOMINGO COMM LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1410 WEST QUITMAN STREET<br/>IUKA, MS 38852</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>On 8/4/21 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the complaint investigation that was conducted on 7/13/21. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements of participation. The SA is recommending your facility be placed back in compliance effective 7/30/21.</p> | {M 000}                                                                                     |                                                                                                                          |                                                                |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

08/12/21