

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47TM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/08/2021
NAME OF PROVIDER OR SUPPLIER GREAT OAKS REHABILITATION AND HEALTHCARE C		STREET ADDRESS, CITY, STATE, ZIP CODE 111 CHASE STREET BYHALIA, MS 38611		
(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 The State Agency (SA) conducted a Complaint Investigation at the facility on 06/07/21 through 06/08/21 for CI MS# 17699 related to quality of care and pressure ulcers. During the survey, the SA determined that the the facility was in compliance with regulations of the Aged and Infirm and was not able to substantiate the allegations. Census at time of the survey was 40 with a bed capacity of 60.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE