

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38JC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/02/2022
NAME OF PROVIDER OR SUPPLIER JAMES T CHAMPION		STREET ADDRESS, CITY, STATE, ZIP CODE 1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307		
(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 follow up/revisit survey on 2/2/22 for an Annual Survey from 11/16/22 through 11/19/22. The facility is license for 60 beds with census at the time of the revisit was 50. The facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements effective 12/29/2021.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

02/28/22