

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 01/09/2020
NAME OF PROVIDER OR SUPPLIER GREAT OAKS REHABILITATION AND HEALTHCARE			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 recertification survey at the facility from 1/6/2020 to 1/9/2020. During the survey, the SA determined the facility was in compliance with Medicare and Medicaid regulations for participation. The SA cited no deficiencies. The facility was licensed for 60 beds and had a census of 54 at the time of the survey.	M 000			

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/17/20