

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20GE	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - GEORGE REGIONAL HEALTH AND REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED R 12/16/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE