

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>60QC</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/23/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>QUITMAN COUNTY HEALTH &amp; REHAB LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>350 GETWELL DRIVE<br/>MARKS, MS 38646</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                                                                            | Initial Comments<br><br>The State Agency (SA) conducted an annual re-certification survey at the facility from 09/20/2021 to 09/23/2021. During the survey, the SA determined that the facility was found to be in compliance with the Mississippi Regulations for the Minimum Standards for the Institutions for the Aged or Infirm. The facility was licensed for 60 beds and had a census of 41 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

10/20/21