

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 69SC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/31/2021
NAME OF PROVIDER OR SUPPLIER SENATOBIA HEALTHCARE & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 402 GETWELL DR SENATOBIA, MS 38668		
(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 CI MS #17486 & CI MS #17566 The State Agency conducted complaint investigations (CI) CI MS #17566 and CI MS #17486 from 03/30/21 through 03/31/21. The facility was found to be in compliance with the Centers for Medicare and Medicaid regulations. CI MS #17486 was not substantiated for discharge. CI MS #17566 was not substantiated for neglect, or quality of care/treatment. No deficiencies cited. The census at the time of the survey was 78.	M 000		

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

TITLE

(X6) DATE