STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HALL HEALTH CARE CENTER	101 MILLS STREET BROOKHAVEN, MS 39601

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey along with a complaint investigation (CI MS #16685, CI MS #16743, CI MS #16943) was conducted by the State Agency (SA) on 9/10/2020. As a result of the survey no new observations related to infection control was noted, however, the facility remains out of compliance based on deficiencies cited during the 2/20/2020 annual recertification survey. At the time of the survey, the facility had a census of 68 and held a license for 61 beds. CI MS #16685 The result of the investigation was unsubstantiated with no deficiencies cited for Misappropriation of Property. However, the facility remains out of compliance based on deficiencies cited during the 2/20/2020 annual recertification survey. CI MS #16743 The result of the investigation was unsubstantiated with no deficiencies cited for Resident Neglect and Quality of Care related to Responsible Party Not Notified. However, the facility remains out of compliance based on deficiencies cited during the 2/20/2020 annual recertification survey. CI MS #16943 The result of the investigation was unsubstantiated with no deficiencies cited for Quality of Care related to Responsible Party Not Notified and Resident Rights related to Resident Privacy Not Protected and Resident Denied Visitation. However, the facility remains out of	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HALL HEALTH CARE CENTER	**101 MILLS STREET BROOKHAVEN, MS 39601**

(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) COMPLETION DATE
F 000	Continued From page 1 compliance based on deficiencies cited during the 2/20/2020 annual recertification survey.	F 000		