

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2020
NAME OF PROVIDER OR SUPPLIER HAVEN HALL HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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