

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 48HM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/17/2019
NAME OF PROVIDER OR SUPPLIER CARE CENTER OF ABERDEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 505 JACKSON ST ABERDEEN, MS 39730		
(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 The State Agency (SA) conducted a complaint survey, MS#16417 at the facility on 12/17/19 related to distribution of alcohol by a resident in the facility. During the survey, the SA determined that the facility was in compliance with the requirements of participation in Medicare and Medicaid. The complaint was not substantiated and had no deficiencies related to this complaint. The census was 101 with a bed capacity of 120 at the time of the investigation.	M 000		

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

TITLE

(X6) DATE