

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35KC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2019
NAME OF PROVIDER OR SUPPLIER MS CARE CENTER OF DEKALB		STREET ADDRESS, CITY, STATE, ZIP CODE 220 WILLOW AVENUE DE KALB, MS 39328		
(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 investigating CI MS 16295 on 10/28/19. The concern identified in the complaint was related to pressure ulcer development. The concerns were not substantiated and no deficiencies were cited. During the survey, the SA determined the facility was in compliance with the requirements for Medicare and Medicaid participation. The facility census at the time of the survey was 59.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE