

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 71IH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/30/2019
NAME OF PROVIDER OR SUPPLIER TISHOMINGO COMM LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 WEST QUITMAN STREET IUKA, MS 38852		
(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# 16238 on 10/30/19. Concerns identified in the facility reported complaint were related to drug diversion. These concerns were substantiated, with no deficiencies cited. During the survey the SA determined the facility was in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had a census of 70 at the time of the complaint survey, with a license for 73 bed capacity.	M 000		

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

TITLE

(X6) DATE