MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35KC	A. BUILDING: _____ B. WING _____	C 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF DEKALB	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 On 06/08/2022 the State Agency (SA) conducted onsite complaint investigations for CI MS #18271-for alleged failure to notify the family of a residents change in condition, and death; CI MS #18808-alleged that Occupational Therapist (OT) had billed for services not provided. The SA unsubstantainted CI MS #18271 and unsubstantiatel CI MS #18808 and no deficiencies were cited. The SA determined that the facility was in substantial complaince with the standards of practice for the Aged and Infirmed. The resident census on 06/08/2022 was 58 and the facility was licensed for 60 beds.	M 000		

Mississippi State Department of Health

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

Electronically Signed | 06/28/22