

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50CH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/20/2022
NAME OF PROVIDER OR SUPPLIER CHOCTAW RESIDENTIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350		
(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 Initial Comments: CI MS #18965 and CI MS #19001 On 10/19/2022 the State Agency (SA) conducted an on site complaint investigation, CI MS #18965 and CI MS #19001 for an alleged event of a resident not getting medications that caused the resident to have an episode of low blood sugar. The SA Unsubstantiated the alleged complaints and no deficiencies were cited. The SA determined that the facility was in compliance with State Licensure Requirements. The facility census was 90 and the facility was licensed for 102 beds on 10/19/2022.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/05/22