

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 11/22/2022
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 at the facility along with a Focused Infection Control Survey from 11/21/22-11/22/22 for MS00019686 for resident food services not honored, therapeutic diet not served and pharmaceutical services and MS00019621 related to an outbreak of bed bugs in the facility and the SA did not substantiate either complaint allegation. During the survey the SA determined that the facility was in compliance with the requirements of The Aged and Infirm. The facility held a license for 73 beds and had a census of 69.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/01/22