

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30PL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/21/2022
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
(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) determined during a Complaint survey, CI: 19972 conducted on 12/21/2022. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm. MS #19972 was not substantiated for resident falls, pressure sores, or notification of responsible representative and no deficiencies were cited.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

01/04/23