

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47TM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/21/2023
NAME OF PROVIDER OR SUPPLIER GREAT OAKS REHABILITATION AND HEALTHCARE C		STREET ADDRESS, CITY, STATE, ZIP CODE 111 CHASE STREET BYHALIA, MS 38611		
(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, MS #20944 at the facility on 03/21/23. During the survey, the SA determined that the facility was in compliance with the Minimal Standards of Operation for Institutions for the Aged or Infirm with no deficiencies were cited. The census at the time of the survey was 54 with a bed capacity of 60 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/07/23