

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>75SL</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/26/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SHADY LAWN HEALTH AND REHABILITATION</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 SHADY LAWN PLACE</b><br><b>VICKSBURG, MS 39180</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                           | <p>Initial Comments</p> <p>The State Agency (SA) conducted a complaint survey, MS #21113, from 4/25/23 to 4/26/23. The SA investigated complaint MS #21113 for Neglect, Quality of care/RP notification, residents not turned timely, ADL's, residents left wet, misappropriation of property and determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited.</p> <p>The facility is licensed for 100 of beds and at the time of the survey the census was 80.</p> | M 000                                                                                             |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/09/23