

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>09FD</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/01/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TRACE EXTENDED CARE &amp; REHABILITATION</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1004 EAST MADISON STREET<br/>HOUSTON, MS 38851</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                                                                               | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI MS #21617) at the facility from 05/31/23 through 06/01/23. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and no deficiencies were cited. The census at the time of survey was 56 and the facility held a license for 66 beds. | M 000                                                                                          |                                                                                                                          |                                                        |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

06/12/23