

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 R-C 06/29/2023
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) completed the facility follow up visit on 06/28/23 through 06/29/23. During this time the facility was placed back into compliance with the requirements for state licensure for the Aged and Infirm with a plan of correction date of 06/22/23. The facility held a license for 73 beds and had a census of 66. The State Agency (SA) completed the facility follow up visit on 06/28/23 through 06/29/23. During this time the facility was placed back into compliance with with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirments with a compliance date of 06/22/23. The facility held a license for 73 beds and had a census of 66.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/06/23