

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 06OG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/22/2023
NAME OF PROVIDER OR SUPPLIER OAK GROVE RETIREMENT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 209 OAK CIRCLE DUNCAN, MS 38740		
(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 revisit survey on 6/22/23 for the complaint survey on 6/1/23 for CI MS 21624. The SA determined the corrective measures put in place by the facility corrected the deficiencies cited on the 6/1/23 survey. At the time of the survey the census was 59 and the facility is licensed for 60 beds.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/21/23