

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09FD	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 07/06/2023
NAME OF PROVIDER OR SUPPLIER TRACE EXTENDED CARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 EAST MADISON STREET HOUSTON, MS 38851		
(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 follow up visit to the facility on 07/05/23-07/06/23 and placed the facility back into compliance with deficiencies that were cited at F600, F656, and F697. The facility was in compliance with the standards for the requirements for The Aged and Infirm. The facility held a license for 66 beds and had a census of 55 at the time of the survey.	{M 000}			

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/17/23