

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 75VT	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/23/2021
NAME OF PROVIDER OR SUPPLIER THE BLUFFS REHABILITATION AND HEALTHCARE C		STREET ADDRESS, CITY, STATE, ZIP CODE 2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180		
(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 CI MS #17574 The State Agency (SA) conducted complaint survey (CI) MS #17574 from 02/23/2021 through 02/23/2021. The SA determined that the facility was in compliance with the Minimum Standards for the Aged or Infirm. The SA did not substantiate CI MS #17574 for quality of care and neglect. No deficiencies were cited. The census at the time of the survey was 95.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE