

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 01/06/2021
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 A complaint investigation was conducted by the State Agency (SA) on 1/5/21-1/6/21 for complaint #17226 and #17295 for the allegation of neglect and quality of care. The complaints were unsubstantiated with no deficiencies cited. The facility census at time of the survey was 91.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE