

Mississippi State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>11/04/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>TUNICA COUNTY HEALTH &amp; REHAB, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1024 HIGHWAY 61 SOUTH , TUNICA, Mississippi, 38676</b>                       |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| M0000                                                                        | Initial Comments<br><br>On 11/4/25 the State Agency (SA) conducted an onsite revisit for the annual survey conducted on 9/29/25-10/1/25. The information reviewed confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 10/31/25.<br><br>The facility had a census of 48 with a license for 60 beds. |                                                       | M0000               |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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