

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER YAZOO CITY REHABILITATION AND HEALTHCARE C		STREET ADDRESS, CITY, STATE, ZIP CODE 925 CALHOUN AVENUE YAZOO CITY, MS 39194		
(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 complaint survey from 5/4/22 to 5/5/22 for CI MS #18770 and CI MS# 18773. During the survey, the SA determined that the facility followed the requirements for the Minimum Standards for the Institutions for the Aged or Infirm. The SA did not substantiate noncompliance with CI MS #18770 Quality of treatment related to unlicensed staff, Facility Staffing, Resident not groomed adequately, Care/Services not received per Physician order, and Resident Safety nor with CI MS# 18773 related to unlicensed staff, Facility Staffing and no deficiencies were cited. The facility was licensed for 180 beds with a census of 118 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

05/10/22