Mississippi State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**07/21/2026** |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br>**MS CARE CENTER OF DEKALB** | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**220 WILLOW AVENUE P O BOX 577, DE KALB, Mississippi, 39328** | |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| M0000 | Initial Comments<br><br>On 07/21/26 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual recertification survey that was completed from 06/15/26-06/18/26. The information provided by the facility confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending your facility be placed back in compliance effective 07/20/26. | M0000 | | |

Office of Primary Care and Health Systems Management

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