

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/20/2021
NAME OF PROVIDER OR SUPPLIER MEMORIAL STONE COUNTY NURSING & REHABILIT/		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(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 a follow up/revisit survey on 9/20/21 for an annual survey that was conducted 8/2/21 through 8/5/21. The State Agency (SA) determined the facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility held a license for 59 beds, with a census of 38.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE