

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>56PH</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>11/21/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PERRY COUNTY NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>202 BAY AVENUE WEST</b><br><b>RICHTON, MS 39476</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 APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                  | <p>Initial Comments</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI), MS #23267 at the facility on 11/21/23. MS #23267 was investigated related to Resident Abuse. There were no deficiencies cited during the survey; however, the facility remains out of compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement due to deficiencies cited on the 11/2/23 licensure survey.</p> <p>The facility held a license for 60 beds, with a census of 49.</p> | M 000                                                                                           |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/01/23