

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49WM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/30/2023
NAME OF PROVIDER OR SUPPLIER WINONA MANOR HEALTH CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 627 MIDDLETON ROAD WINONA, MS 38967		
(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 revisit to a complaint survey at the facility from on 11/30/23. During the survey, the SA determined that the actions taken by the facility corrected the deficiencies cited on the 09/28/2023 survey as of 11/03/2023. The SA is recommending the facility be placed back in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements effective 11/22/2023, the compliance date of the 10/18/2023 survey. The facility held a license for 119 beds at the time of the survey, and the facility census was 91.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/18/23