

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2024
NAME OF PROVIDER OR SUPPLIER SARDIS COMMUNITY NH			STREET ADDRESS, CITY, STATE, ZIP CODE 613 EAST LEE STREET SARDIS, MS 38666		
(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	
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #23740) at the facility on 2/7/24. During the survey, the SA determined that the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated neglect and staffing with no deficiencies cited. The facility held a license for 60 beds, with a census of 57.	F 000			

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

Electronically Signed

TITLE

(X6) DATE

02/12/2024