

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 03/04/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT			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 an annual recertification survey at the facility from 01/23/24 through 01/25/24. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care Unit and there were no deficiencies cited.	{M 000}			

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/07/24