

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>52NO</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/18/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NOXUBEE COUNTY NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>78 HOSPITAL RD</b><br><b>MACON, MS 39341</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 MS #24472 and MS #24758 at the facility from 04/16/24 through 04/18/24. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and there were no deficiencies cited.</p> <p>The facility held a license for 60 beds at the time of the survey, and the facility census was 58.</p> | M 000                                                                                    |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/26/24