

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-C 05/13/2024
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 follow-up survey, at the facility on 5/13/24, after a complaint survey with deficiencies 4/8/24 through 4/9/24. The SA recommends putting the facility back into compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm effective 5/9/24. The facility is licensed for 120 beds and at the time of the survey the census was 93.	{M 000}		

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

TITLE

(X6) DATE

Electronically Signed

05/16/24