

|                                                                        |                                                                                                                              |                                                                            |                                                                                                                          |                            |                                                                    |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255072</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/25/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINSTON COUNTY NURSING HOME</b> |                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>17560 EAST MAIN STREET</b><br><b>LOUISVILLE, MS 39339</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>COMPLETION<br>DATE |                                                                    |
| {E 000}                                                                | Initial Comments                                                                                                             | {E 000}                                                                    |                                                                                                                          |                            |                                                                    |

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

TITLE

(X6) DATE  
  
05/14/2024