

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 80TC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/30/2019
NAME OF PROVIDER OR SUPPLIER LOUISVILLE HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 543 EAST MAIN STREET LOUISVILLE, MS 39339		
(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 Abbreviated/Partial survey investigating CI# MS 15890 on 08/30/19. Based on record reviews of the Care Plan, Incident Report, Medical Records, Nurses Notes, Records reporting to SA and interviews, the survey revealed the complaint was substantiated with no deficiencies cited.	M 000		

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

TITLE

(X6) DATE