

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/13/2024
NAME OF PROVIDER OR SUPPLIER SHADY LAWN HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 60 SHADY LAWN PLACE VICKSBURG, MS 39180		
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS On 06/13/24 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual survey that was completed on 05/02/24. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with Medicare and Medicaid requirements of participation. The SA is recommending that your facility be placed back in compliance effective 06/12/24.	{F 000}			

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

Electronically Signed

TITLE

(X6) DATE

06/13/2024