

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255164		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/08/2024	
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 910 MAIN STREET FAYETTE, MS 39069			
(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 The State Agency (SA) conducted a Complaint Investigation (CI), MS #25839 at the facility on 8/8/24. MS #25839 was investigated for injury of unknown origin. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and there were no deficiencies cited. The facility held a license for 60 beds, with a census of 44.			F 000			

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

Electronically Signed

TITLE

(X6) DATE

08/13/2024