

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2024
NAME OF PROVIDER OR SUPPLIER STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOSPITAL ROAD STARKVILLE, MS 39759		
(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 26498 at the facility on 9/17/24. During the survey, the SA determined that the facility was compliant with the requirements for participation in Medicare and Medicaid. There were no deficiencies cited for MS 26498 realted to Abuse and Missappropriation. The census at the time of the survey was 112 and the facility is licensed for 119 beds.	F 000			

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

Electronically Signed

TITLE

(X6) DATE
09/30/2024