MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27BN	A. BUILDING: _____ B. WING _____	R-C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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 On 2/21/25 the State Agency (SA) conducted an onsite revisit for the annual survey that was completed on 12/12/24. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with Minimum Standards for Institutions for the Aged or Infirm, as of 1/10/25. However, the facility remains out of compliance due to deficiencies cited on the 1/15/25 complaint survey. At the time of the survey the facility census was 49 with a bed capacity of 60 beds.	{M 000}		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/07/25