

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49WM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/09/2021
NAME OF PROVIDER OR SUPPLIER WINONA MANOR HEALTH CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 627 MIDDLETON ROAD WINONA, MS 38967		
(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 A Complaint Investigation (CI) for Complaint # 17954 was conducted on 9/9/21 with allegations against Administration/Personnel. The allegations were unsubstantiated with no deficiencies cited. The facility is licensed for 120 beds and had a census of 78 at the time of survey.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE