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
	49WM	A. BUILDING: _____ B. WING _____	R 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATI(	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 On 4/30/25 the State Agency (SA) conducted an onsite revisit for the annual survey and complaint investigation that was completed on 3/27/25. The information reviewed confirmed that the facility had put measure in place to correct the deficient practice and sustain complaince with the Mississippi Regulations for the Minimum Standards for the Institutions for the Aged or Infirm. The SA is recommending that the facility be placed back into compliance effective 4/24/25. The census at the time of the revisit survey was 97 and the facility held a license for 120 beds.	{M 000}		

Mississippi State Department of Health

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

Electronically Signed | 05/06/25