

Mississippi State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>11/07/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>YALOBUSHA COUNTY NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>630 SOUTH MAIN STREET , WATER VALLEY, Mississippi, 38965</b>                 |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                               |                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| M0000                                                                | Initial Comments<br><br>On 11/07/25 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual survey that was completed on 10/09/25. The information provided by the facility confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending your facility be placed back in compliance effective 11/01/25. |                                                       | M0000               |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

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