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
	81YC	A. BUILDING: _____ B. WING _____	C 06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YALOBUSHA COUNTY NURSING HOME	630 SOUTH MAIN STREET WATER VALLEY, MS 38965

(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 CI MS #17573 The State Agency (SA) conducted a complaint investigation (CI), CI MS #17573 on 6/3/21. During the survey, the SA determined the facility was in compliance with the Minimum Standards for the Aged or Infirm requirements for participation. The SA did not substantiate CI MS #17573 for misappropriation of property or quality of care. No deficiencies were cited. The census at the time of the survey was 89 and the facility is licensed for 122 beds.	M 000		

Mississippi State Department of Health

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