

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255130		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/05/2026	
NAME OF PROVIDER OR SUPPLIER TIPPAH COUNTY NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1005 CITY AVENUE NORTH PO BOX 499, RIPLEY, Mississippi, 38663			
(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) COMPLETION DATE
F0000	INITIAL COMMENTS On 05/05/26 the State Agency (SA) conducted an onsite revisit related to the annual survey that was completed on 02/19/26. The SA determined that the corrective measures taken by the facility corrected the deficiencies cited on the 02/19/26 survey as of 03/24/26. However, the facility remained out of compliance with the requirement of participation in Medicare and Medicaid until 04/30/26, the compliance date for the 03/26/26 Federal Comparative Survey. The census at the time of survey was 31 and the facility held a license for 40 beds.			F0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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