

MSDH - Health Facilities Licensure and Certification

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                                                                                          |                                                                    |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>66SR</b>                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/31/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MEMORIAL STONE COUNTY NURSING &amp; REHABILIT/</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1436 EAST CENTRAL AVENUE</b><br><b>WIGGINS, MS 39577</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 APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                                     | <p>Initial Comments</p> <p>The State Agency (SA) conducted a complaint survey, MS #18460 and MS #17986, at the facility from 1/28/2022 through 1/31/2022. The SA did not substantiate the complaint of elopement or resident's left wet for extended periods. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm and there were no deficiencies cited.</p> <p>The facility held a license for 60 beds, with a census of 59.</p> | M 000                                                                                                |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

02/10/22