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
	45WB	A. BUILDING: _____ B. WING _____	C 06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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 The State Agency (SA) conducted a complaint survey, MS #17458, MS #17348 and MS #17419 from 6/7/21 to 6/9/21. The SA did not substantiate the complaints MS #17458 for Infection Control related to Covid and not answering the phones, MS #17438 for Resident Neglect related to medications, Quality of Care related to a resident left soiled for extended periods of time, Infection Control practices by the facility, Staffing by the facility and Rehabilitation services, MS #17419 for Resident Neglect related to assessing and monitoring, Quality of Care related to Infection Control Practices by the facility and water not offered to the resident with no citations. The census was 51 with 60 beds.	M 000		

Mississippi State Department of Health

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