

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53SM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/07/2021
NAME OF PROVIDER OR SUPPLIER STARKVILLE MANOR HEALTH CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOSPITAL ROAD STARKVILLE, MS 39759		
(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 #17700, MS #17604, MS #17487, MS #17312, MS#17068, and MS#16795 at the facility from 7/6/21 to 7/7/21. The SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA did not substantiate the complaints for Dignity, Quality of Care, Pain medication, weight loss assessment, rehabilitation services, assess and monitoring, inappropriate feeding assistance, telephone use, and staffing and no deficiencies were cited. The facility held a license for 119 beds and had a census of 113 at the time of the survey.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE