

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2020  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255275</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/20/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MAGNOLIA SENIOR CARE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3701 PETER QUINN DRIVE<br/>JACKSON, MS 39213</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>COMPLETION<br>DATE                             |
| F 000                                                                | <p><b>INITIAL COMMENTS</b></p> <p>The State Agency (SA) conducted an annual re-certification survey at the facility from 3/18/19 to 3/20/19. During the survey, the SA determined that the facility was in compliance with Medicare and Medicaid requirements for participation.</p> <p>The census at the time of the survey was 58, with a bed capacity of 60.</p> | F 000                                                                      |                                                                                                                          |  |                                                        |

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

TITLE

(X6) DATE

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 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.

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| K 000                                                                | <p>INITIAL COMMENTS</p> <p>42 CFR 483.70(a)</p> <p>The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).</p> <p>There were no LSC deficiencies cited during this survey.</p> | K 000                                                                      |                                                                                                                          |  |                                                        |

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| E 000                                                                | Initial Comments<br><br>*EMERGENCY PREPAREDNESS*<br><br>Survey conducted on 3/18/19 reveals the above<br>facility meets all applicable Federal, State and<br>local emergency preparedness requirements.<br><br>No deficiencies were identified. | E 000                                                                      |                                                                                                                          |  |                                                        |

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