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
	56PH	A. BUILDING: _____ B. WING _____	R-C 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 follow up/revisit survey at the facility on 11/23/21 for complaint investigation (CI) MS #18150, CI MS #18021, CI MS #18134, CI MS #18058, and an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) from 10/4/21 through 10/16/21. The facility was in compliance with the Mississippi Regulations for Minimum Standards of for Institutions for the Aged or Infirm.	{M 000}		

Mississippi State Department of Health

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