

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 80WC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/19/2019
NAME OF PROVIDER OR SUPPLIER WINSTON COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 17560 EAST MAIN STREET LOUISVILLE, MS 39339		
(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 Survey Agency (SA) conducted a complaint investigation CI MS# 16112 on 9/19/19. The result of the investigation was unsubstantiated for Resident's Rights with no deficiencies cited. The SA determined the facility was in compliance with Medicare and Medicaid requirements for participation.	M 000		

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

TITLE

(X6) DATE