

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49WM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/21/2019
NAME OF PROVIDER OR SUPPLIER WINONA MANOR HEALTH CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 627 MIDDLETON ROAD WINONA, MS 38967		
(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 investigating CI MS#16364 and CI MS#16386 on 11/19/19-11/21/19. Concerns identified in the complaint # 16363 were related to possible quality of care and treatment. These concerns were not substantiated, and no deficiencies were cited. Concerns identified in the complaint # 16386 were related to resident rights. These concerns were not substantiated and no deficiencies were cited. During the survey the SA determined the facility was in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had a census of 110 at the time of the complaint survey, with a license for 120 bed capacity.	M 000		

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

TITLE

(X6) DATE