

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 64HH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/16/2022
NAME OF PROVIDER OR SUPPLIER HILLCREST NURSING CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 FIRST AVENUE NORTHEAST MAGEE, MS 39111		
(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 for MS #18117 at the facility on 3/16/22. During the survey the SA determined the facility was in compliance with Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm with citations. The SA did not substantiate the MS #18117 for mold and leaks in the ceilings, understaffing, residents not being assisted with meals, and infection control related to COVID-19. There were no deficiencies cited.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

03/22/22