

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 06/08/2022
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 complaint survey for CI MS# 18703 and CI MS #18718 at the facility from 06/06/2022 to 06/08/2022 along with an Employee Vaccination section of the Infection Control survey. During the survey, the SA determined that the facility followed the Minimum Standards for the Institutions for the Aged or Infirm. The SA did not substantiate noncompliance with CI MS #18703 Related to Injury of unknown origin or CI MS 181718 related to Abuse were not substantiated and there were no deficiencies cited. The Facility was licensed for 120 beds and the census was 78 at the time of the survey.	M 000		

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

TITLE

(X6) DATE