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
	80TC	A. BUILDING: _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	543 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 Agency (SA) conducted complaint survey for MS00018821, MS00018752, and MS00019084 at the facility from 06/13/2022 to 06/16/2022 along with an Employee Vaccination section of the Infection Control survey. During the survey, the SA determined that the facility followed the requirements for participation with The Aged and Infirmed. MS00018821 related to Physical environment/pest, and dietary services with cold food, MS00018752 related to Quality-of-Care Treatment, Equipment, Food Cold, No weight loss assessment by facility, and MS00019084 related to Physical Environment/Pest, Quality-of-care inappropriate Feeding assist for weight loss, Medications not given, Facility staffing, dietary services therapeutic diets not provided, and insufficient food, Labs not collected and pharmaceutical services were not substantiated and there were no deficiencies cited. The facility was licensed for 60 beds and the census was 49 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

Electronically Signed | 06/29/22