STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255096	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted complaint survey for CI MS #18821, CI MS #18752, and CI MS #19084 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 in Medicare and Medicaid. CI MS #18821 related to Physical environment/pest, and dietary services with cold food, CI MS #18752 related to Quality-of-Care Treatment, Equipment, Food Cold, No weight loss assessment by facility, and CI MS #19084 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/29/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.