

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 67WC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/02/2022
NAME OF PROVIDER OR SUPPLIER WALTER B CROOK NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 840 NORTH OAK AVENUE RULEVILLE, MS 38771		
(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 conducted a complaint survey, MS #00019387, from 8/01/22 to 8/02/22. During the survey, the SA determined that the facility was in compliance with the Minimum Standard of Operation for Institutions for the Aged or Infirm, state licensure requirements. At the time of the survey the facility census was 56 and the facility is licensed for 60 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE