

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 10/20/2022
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 Survey Agency (SSA) conducted a Complaint Investigation (CI), MS #19587 and MS#18722 at the facility from 10/19/2022 through 10/20/2022. During the survey, the SSA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SSA did not substantiate MS #19587 for Dietary Services related meals, Quality of Care related to grooming, and Residents Rights related to activities or MS #18722 for Dietary Services related food and Resident Rights related to lack of activities and cited no deficiencies.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/24/22