

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>45WB</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/01/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE NICHOLS CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1308 HIGHWAY 51 NORTH<br/>MADISON, MS 39110</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| M 000                                                         | <p>Initial Comments</p> <p>The State Agency (SA) conducted an annual recertification survey at the facility from 11/28/22 through 12/1/22. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. No deficiencies were cited.</p> <p>At the time of the survey, the facility had a census of 51 and held a license for 60 beds.</p> | M 000                                                                                       |                                                                                                                          |                                                        |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/19/22