PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255137	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NESHOBA COUNTY NURSING HOME	1001 HOLLAND AVENUE PHILADELPHIA, MS 39350

(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	F 000		

CI MS #15783
The State Agency (SA) conducted a complaint survey, MS #15783 at the facility on 5/14/19 to 5/16/19 and was not able to substantiate abuse or neglect. Also the SA was unable to substantiate staff sleeping, unreported falls, medications not being given, rooms and bathrooms not clean. There were no identified concerns related to staffing.

CI MS #15888
The State Agency (SA) conducted a complaint survey, MS #15888 at the facility on 5/14/19 to 5/16/19 and was not able to substantiate the complaint for abuse.

CI MS #15889
The State Agency (SA) conducted a complaint survey, MS #15889 at the facility on 5/14/19 to 5/16/19 and was not able to substantiate unreported falls and unreported and untreated pressure ulcers.

CI MS #15892
The State Agency (SA) conducted a complaint survey, MS #15892 at the facility on 5/14/19 to 5/16/19 and was not able to substantiate undocumented falls and not treating pressure ulcers.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] NHA		6/3/19

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.