

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 76GC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/13/2023
NAME OF PROVIDER OR SUPPLIER LEGACY MANOR NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704		
(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 (SA) conducted a complaint survey, MS #21116, on 4/13/23. The SA determined during the survey the investigation for the complaint CI 21116 for a resident being left wet, not clean and not offered water was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Inform with no deficiencies cited. The facility is licensed for 60 of beds and at the time of the survey the census was 50 and 1 evacuee.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/01/23