

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>67WC</b>                           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/27/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WALTER B CROOK NURSING FACILITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>840 NORTH OAK AVENUE</b><br><b>RULEVILLE, MS 38771</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 a complaint survey, MS# 21908, from 6/26/23 to 6/27/23. The SA investigated complaint MS# 21908 related to Sufficient and Competent Staffing, Neglect, Dental, Accidents and Quality of Care/Treatment. Resident #1. During the survey the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited.</p> <p>The facility is licensed for 60 of beds and at the time of the survey the census was 50.</p> | M 000                                                                                              |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/05/23