

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21MM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/12/2022
NAME OF PROVIDER OR SUPPLIER LEAKESVILLE REHABILITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MELODY LANE LEAKESVILLE, MS 39451		
(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 Investigation (CI), MS #19021, MS #19338, and MS #19341, at the facility from 7/11/22 through 7/12/22. The SA did not substantiate MS #19021 and MS #19338 for misappropriation of property. The SA did not substantiate MS #19341 for food not palatable and resident food preferences not honored. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and there were no deficiencies cited.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE