

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25MH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MAGNOLIA SENIOR CARE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 PETER QUINN DRIVE JACKSON, MS 39213
--	--

(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	<p>Initial Comments</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI), MS #24872, at the facility from 7/9/24 through 7/10/24. MS #24872 was investigated related to injury of unknown origin, resident not groomed, resident assessment, and responsible representative not being informed of resident condition. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. There were no deficiencies cited.</p>	M 000		

Mississippi State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE 	(X6) DATE 07/27/24
--	---------------	----------------------------------