

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/08/2026	
NAME OF PROVIDER OR SUPPLIER LOUISVILLE HEALTHCARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 543 EAST MAIN STREET , LOUISVILLE, Mississippi, 39339			
(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
M0000	Initial Comments The State Agency (SA) conducted three (3) Complaint Investigations (CI MS #2748377, CI MS #2791754, and CI MS #2993949) at the facility on 06/08/26. During the survey the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and there were no deficiencies cited. The SA investigated Resident Rights, Misappropriation of Property, Homelike Environment, and Activities of Daily Living with no deficiencies cited. The facility held a license for 60 beds at the time of the survey, and the facility census was 55.			M0000			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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