

Mississippi State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                      |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>08/12/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOLMES COUNTY LONG TERM CARE CENTER - DURANT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                       |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>15481 BOWLING GREEN ROAD , DURANT, Mississippi, 39063</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<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| M0000                                                                                   | <p>Initial Comments</p> <p>The State Agency (SA) conducted a Complaint Investigation (CI) MS# 3094965, MS# 3094389, MS# 3118679 and MS# 3152574 at the facility on 8/12/26. During the survey, the SA determined that the facility was in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm and there were no deficiencies cited.</p> <p>Census at the time of the survey was 73 with a bed capacity of 80 beds.</p> |                                                       |  | M0000                                                                                                     |                                                                                                                          |                                                 |                            |

Office of Primary Care and Health Systems Management

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