

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44AA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/21/2023
NAME OF PROVIDER OR SUPPLIER AURORA HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 EMERALD DRIVE COLUMBUS, MS 39702		
(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 two (2) complaint investigations (CI MS #22692 and CI MS #22716) at the facility from 09/20/23 through 09/21/23. During the Survey, the SA determined that the facility was in compliance with the Minimal Standards of Operation for Institutions for the Aged or Infirm and no deficiencies were cited. The census at the time of the complaint survey was 80 and they were licensed for 120 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

09/27/23