MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44AA	A. BUILDING: _____ B. WING _____	R-C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	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 a complaint survey for CI MS #16986, CI MS #17223, CI MS #17227, and CI MS #17314 at the facility from 02/24/21 through 02/26/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #17314 and CI MS #17227 for quality of care regarding pressure ulcers and cited F686 at the "G" level. CI MS #16986 was not substantiated for Neglect, and CI MS #17223 was not substantiated for pressure sores, infection control, and environment. The census at the time of suvey was 81.	{M 000}		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE