

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 67CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/08/2024
NAME OF PROVIDER OR SUPPLIER INDIANOLA REHABILITATION AND HEALTHCARE CEI		STREET ADDRESS, CITY, STATE, ZIP CODE 401 HIGHWAY 82 WEST INDIANOLA, MS 38751		
(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 investigation (CI) for MS# 24885, CI MS# 25576, and CI MS# 25647 at the facility on 7/8/24. During the survey, the SA determined that the facility was in compliance with the requirements of participation with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. There were no deficiencies cited for CI MS# 24885 related to Resident Rights, CI MS# 25576 related to Neglect or CI MS# 25647 related to Falls. The census at the time of the survey was 69 with a bed capacity of 75 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/15/24