

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01TH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/02/2024
NAME OF PROVIDER OR SUPPLIER NATCHEZ REHABILITATION AND HEALTHCARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 344 ARLINGTON AVENUE NATCHEZ, MS 39120		
(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), MS #25594 at the facility from 7/1/24 through 7/2/24. MS #25594 was investigated related to incontinent care, feeding assistance, resident rights and wound care. Although there were no deficiencies cited related to the complaint investigation, the facility remains out of compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement due to deficiencies cited on the 06/05/24 survey.	M 000			

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/17/24