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
	67CI	A. BUILDING: _____ B. WING _____	R-C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANOLA REHABILITATION AND HEALTHCARE CE	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 On 09/17/24 the State Agency (SA) conducted an onsite revisit related to a complaint survey that was completed on 07/31/24. The information reviewed confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 09/11/24. The facility is licensed for 75 beds and at the time of the survey the census was 70.	{M 000}		

Mississippi State Department of Health

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

Electronically Signed | 09/27/24