

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 73RR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2025
NAME OF PROVIDER OR SUPPLIER NEW ALBANY HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652		
(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 #28133 at the facility on 03/27/25. During the survey, the SA determined that the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and there were no deficiencies cited. The census at the time of the survey was 90 and they held a license for 114 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/03/25