

MSDH - Health Facilities Licensure and Certification

|                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                     |                                                                                                                          |                                                                    |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>46FM</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/25/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLUMBIA REHABILITATION AND HEALTHCARE CEI</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1506 NORTH MAIN STREET</b><br><b>COLUMBIA, MS 39429</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                                                 | <p>Initial Comments</p> <p>The State Agency (SA) conducted a complaint survey, CI MS# 17468, CI MS# 17382, CI MS# 17403, and CI MS# 17843 at the facility from 6/23/21 to 6/25/21. During the survey, the SA determined that the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements. Based on investigation findings, the SA was unable to substantiate allegations that the facility failed to prevent the verbal abuse of a resident, failed to answer/return calls to family members, failed to prevent pressure ulcers, and failure to groom residents properly. At the time of the survey the facility was licensed for 108 beds and had a census of 76.</p> | M 000                                                                                               |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE