

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2021  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                          |                            |                                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255227</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>06/25/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLUMBIA REHABILITATION AND HEALTHCARE CENTER</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>COMPLETION<br>DATE |                                                                        |
| F 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 requirements of participation in Medicare and Medicaid. 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> | F 000                                                                      |                                                                                                                          |                            |                                                                        |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.