

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/24/2025	
NAME OF PROVIDER OR SUPPLIER NATCHEZ REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 344 ARLINGTON AVENUE , NATCHEZ, Mississippi, 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) COMPLETION DATE	
M0000	Initial Comments The State Agency (SA) conducted a desk review on 12/24/25 related to the annual survey that was conducted from 09/25/25. The SA determined that the corrective measures taken by the facility corrected the deficiencies cited on the 09/25/25 survey as of 11/21/25. However, the facility remained out of compliance with the requirements of participation in the Minimum Standards for The Aged and Infirm, state licensure requirements until 12/23/25, the compliance date for the 12/23/25 survey.		M0000				

Office of Primary Care and Health Systems Management

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