

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 02/12/2026	
NAME OF PROVIDER OR SUPPLIER INDIANOLA REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 401 HIGHWAY 82 WEST , INDIANOLA, Mississippi, 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) COMPLETION DATE
M0000	Initial Comments On 2/12/26 the State Agency (SA) conducted an onsite revisit for the survey completed on 1/14/26. The information reviewed confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 2/5/26. The census at the time of survey was 61 with a license for 75 beds.			M0000			

Office of Primary Care and Health Systems Management

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