

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/22/2021
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635		
(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 complaint investigations, CI MS #17218, CI MS #17237, CI MS #17453, at the facility on 1/22/21 The result of the investigation was unsubstantiated for quality of care and neglect with no deficiencies cited. The SA determined that the facility was in compliance with the Minimum Standards for the Aged or Infirm.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

02/12/21