

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 67CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/14/2019
NAME OF PROVIDER OR SUPPLIER INDIANOLA REHABILITATION AND HEALTHCARE CEI		STREET ADDRESS, CITY, STATE, ZIP CODE 401 HIGHWAY 82 WEST INDIANOLA, MS 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification along with a complaint MS #16373 from 1/12/19 to 11/14/19. During the survey the SA determined that the facility was in compliance with the requirements for participation in the Minimum Standards for the Aged or Infirm, with no deficiencies cited. The SA did not substantiate MS 16373 for abuse, with no deficiencies related to the complaint. The facility is licensed for 75 beds and the census at the time of survey was 73.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed