

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05BE	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2021
NAME OF PROVIDER OR SUPPLIER ASHLAND HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 16056 BOUNDARY DRIVE ASHLAND, MS 38603		
(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 a complaint survey, CI #17738 at the facility on 04/21/21. The SA did not substantiate the complaint related to facility staffing and cited no deficiencies. The SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The census at the time of the survey was 40 with a bed capacity of 60.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE