

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44AA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/17/2019
NAME OF PROVIDER OR SUPPLIER AURORA HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 310 EMERALD DRIVE COLUMBUS, MS 39702		
(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 abbreviated/partial extended survey investigating CI MS# 16253 beginning 10/17/19. Concerns identified in the complaint were Infestation of Bugs and Lift that does not work. Based on observations and review of the Care Plan, Medical Records, Medication Administration Record, Social Service Noted, Progress Notes, Physician Orders, and Nurses Notes; the surveyor was unable to obtain substantial evidence to prove any deficient practice by the facility related to lift availability or unavailability; therefore no deficiencies were cited.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE