

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 12/12/2019
NAME OF PROVIDER OR SUPPLIER ASHLAND HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 16056 BOUNDARY DRIVE/PO BOX 490 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) determined during an annual recertification survey, conducted from 12/09/19 to 12/11/19. The SA determined the facility was in compliance with the the Mississippi Regulations for the Minimum Standards for the Institutions for Aged or Infirm.	M 000			

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

TITLE

(X6) DATE