

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 73RR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2020
NAME OF PROVIDER OR SUPPLIER NEW ALBANY HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652		
(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 investigating MS00016503 on 3/12/2020 - 3/13/2020. Concerns identified in the complaint were related to quality of care, hydration, nutrition and weight loss, positioning with tube feeding, activities of daily living (ADL) care and bathing, and failure to notify family of scheduled appointment. During the survey the SA determined the facility was in substantial compliance with requirements for participation. The facility had a census of 97 with a license for 120 bed capacity.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE