

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 08/17/2022
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 an annual recertification survey with a complaint investigation CI MS #19315 at the facility from 08/14/22 to 08/17/22. During the survey, the SA determined that the facility was in compliance with the Minimum Standards of Institutions for Aged or Infirm. The SA was unable to substantiate CI MS #19315 for neglect and quality of care. At the time of survey, the facility had a census of 45 and licensed for 60 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

08/30/22