MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01TH	A. BUILDING: _____ B. WING _____	C 07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATCHEZ REHABILITATION AND HEALTHCARE CEN	344 ARLINGTON AVENUE NATCHEZ, MS 39120

(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 MS#17920 at Natchez Rehabilitation and Healthcare from 07/26/21 through 07/27/21. During the survey, the SA determined the facility was in compliance with the requirements with Minimum Standards for Institutions for the Aged or Infirm. The SA was not able to substantiate the complaint for verbal abuse of a resident and no deficiencies were cited. At the time of the survey the facility had a census of 48 residents and was licensed for 55 residents.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE