

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/30/2021
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635		
(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 two (2) complaint surveys at your facility from 6/29/21 to 6/30/21. The complaint CI MS# 17768 was not substantiated for assessment related to urinary tract infection post discharge from the facility. The complaint CI MS# 17764 was not substantiated for misappropriation of property. The SA found the facility to be in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and state licensure requirements. The facility had a census of 91 and held a license for 120 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE