

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/22/2024
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMUNITY LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645		
(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) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The State Agency (SA) conducted a follow-up revisit at the facility on 10/22//24 related to the Federal Monitoring survey that was conducted from 9/09/24 through 9/13/24. The SA found the facility to be in compliance with the requirements of participation in Medicare and Medicaid and recommends the facility be placed back in compliance effective 10/18/24.	{F 000}			

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

Electronically Signed

TITLE

(X6) DATE
10/28/2024