

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/15/2026	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMUNITY LIVING CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 323 INDUSTRIAL PARK DRIVE , LIBERTY, Mississippi, 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	
M0000	Initial Comments The State Agency (SA) conducted a follow-up revisit at the facility from 1/14/26 through 1/15/26 related to the recertification and complaint survey that was conducted from 12/01/25 through 12/04/25. The SA determined the facility was in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care Unit and recommends the facility be placed back into compliance effective 1/12/26.		M0000				
M0000	Initial Comments The State Agency (SA) conducted a follow-up revisit at the facility from 1/14/26 through 1/15/26 related to the recertification and complaint survey that was conducted from 12/01/25 through 12/04/25. The SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and recommends the facility be placed back into compliance effective 1/12/26.		M0000				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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