

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03AC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/21/2023
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) COMPLETE DATE
{M 000}	Initial Comments On 3/21/23 the State Agency (SA) conducted desk review of the information that was provided to our agency related to the annual survey that was completed on 02/02/23. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care Unit. The SA is recommending that your facility be placed back in compliance effective 03/10/23.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

03/22/23