

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23WV	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/16/2024
--------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER MEMORIAL WOODLAND VILLAGE NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5427 GEX ROAD DIAMONDHEAD, MS 39525
-------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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}	<p>Initial Comments</p> <p>The State Agency (SA) conducted an annual recertification survey at the facility from 02/26/24 through 02/29/24. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care Unit and there were no deficiencies cited.</p>	{M 000}		

Mississippi State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/16/24
----------------------------------------------------------------------------------------------------------------------------------------------	-------	------------------------------