

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>23WV</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>04/16/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MEMORIAL WOODLAND VILLAGE NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5427 GEX ROAD DIAMONDHEAD, MS 39525</b>
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(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>On 04/16/24 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual survey that was completed on 02/29/24. The information provided by the facility confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 04/10/24.</p>	{M 000}		

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