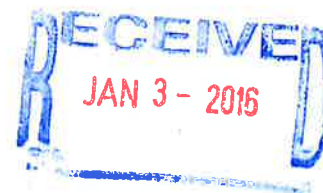


MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MS45SI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/19/2016
NAME OF PROVIDER OR SUPPLIER ST CATHERINE'S VLG/SIENA CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 200 DOMINICAN DRIVE MADISON, MS 39110		
(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 CI MS #14320 A complaint investigation was conducted in your facility on 12/19/16. The result of the investigation was substantiated with no deficiencies cited.	M 000		



Mississippi State Department of Health

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

Mary Margaret Jolly

TITLE

Executive Director

(X6) DATE

12/30/16

STATE FORM

6899

P56411

If continuation sheet 1 of 1