

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 05/19/2016
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 #13987 The State Agency conducted a complaint survey for complaint #13987 at the facility on 5/18/16 - 5/19/16. The complaint was unsubstantiated and determined the facility was in compliance with state requirements for participation. No deficiencies were cited. The census at the time of survey was 85.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE