

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25JW	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2017
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NAME OF PROVIDER OR SUPPLIER JACKSON WOMEN'S HEALTH ORGANIZATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 NORTH STATE STREET JACKSON, MS 39216
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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
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M 000	<p>Initial Comments</p> <p>- Health -</p> <p>** AMBULATORY SURGICAL CENTERS (ASC) REGULATIONS **</p> <p>Annual licensure survey conducted 08/22/2017 revealed the facility was in compliance with the Minimum Standards of Operation for Ambulatory Surgical Centers.</p> <p>No deficiencies were cited.</p>	M 000		
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Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____