

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2023
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301
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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>The State Agency (SA) conducted a Complaint Investigation (CI), MS #22898 and MS #22752, at the facility, from 10/10/23 through 10/11/23. The SA investigated MS #22898 related to improper incontinence care MS #22752 for services not performed per the plan of care, resident not turned and repositioned, resident not groomed, and resident left wet for extended periods. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. 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
10/25/23