

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                          |                            |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255118</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/11/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DIVERSICARE OF MERIDIAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4728 HIGHWAY 39 NORTH</b><br><b>MERIDIAN, MS 39301</b>                       |                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                    |
| F 000                                                              | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted two Complaint Investigations (CI MS #22898 and CI 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 facility was found to be in compliance with the requirements of participation in Medicare and Medicaid, and there were no deficiencies cited.</p> <p>The facility had a census of 91, with a bed capacity of 120.</p> | F 000                                                                      |                                                                                                                          |                            |                                                                    |

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

TITLE

(X6) DATE

Electronically Signed

10/25/2023

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.