

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 48AM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/30/2023
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF AMORY		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 EARL FRYE DRIVE AMORY, MS 38821		
(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 The State Agency (SA) conducted a revisit at the facility on 11/29/23 through 11/30/23 and placed the facility back into compliance for M500 for residents' rights, M610 for Activities of Daily Living, M815 for safe food handling procedures, M1010 for housekeeping facilities and services, and M1570 for infection control. The census at the time of the survey was 103 with a bed capacity for 152 residents.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/04/23