

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/04/2024
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SOUTHAVEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1730 DORCHESTER DR SOUTHAVEN, MS 38671		
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS The State Agency (SA) conducted a follow up survey at the facility on 6/4/24 related to the complaint survey that was conducted on 5/8/24. During the survey, the SA determined that the facility was in compliance with the requirements of Medicare and Medicaid requirements of participation. The SA is recommending the facility be placed back in compliance effective 6/3/24. At the time of the survey the facility census was 125 with a bed capacity of 140 beds.	{F 000}			

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

Electronically Signed

TITLE

(X6) DATE

06/07/2024