

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 C 05/30/2024
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 two (2) Complaint Investigations (CI MS #25064 and CI MS #25066) at the facility on 05/30/24. The SA investigated facility staffing, infection control, misappropriation of property and nursing services. Although there were no deficiencies cited during the complaint investigation the facility remains out of compliance with the requirements for participation in Medicare and Medicaid due to deficiencies cited on the 03/20/24 and 05/08/24 surveys. The census at the time of the survey was 133 and they held a license for 140 beds.	F 000			

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

Electronically Signed

TITLE

(X6) DATE

06/07/2024