

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/07/2024
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301		
(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 Complaint Investigation, CI #25517, at the facility from 8/6/24 to 8/7/24. The complaint was a facility reported incident regarding an allegation of abuse. During the investigation, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and there were no deficiencies cited. The facility had a census of 94 and was licensed for 120 beds.	F 000			

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

Electronically Signed

TITLE

(X6) DATE

08/23/2024