

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 C 11/19/2024
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 complaint investigation (CI MS# 26213 and CI MS #26563) at the facility on 11/19/24. During the survey the SA determined that the facility was in compliance with the Minimal Standards of Operation for Institutions for the Aged or Infirm. The SA investigated CI MS #26213 and CI MS #26563 related to resident neglect and there were no deficiencies cited. The census at the time of the complaint investigation was 106 and they held a license for 152 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/26/24