

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17SH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/22/2025
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) COMPLETE DATE
{M 000}	Initial Comments On 04/22/25 the State Agency (SA) conducted an onsite revisit for the complaint investigation that was completed on 03/26/25. The information reviewed confirmed that the facility had put measures in place to correct the deficient practice as of 04/16/25. The SA is recommending that your facility be placed back in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm for both the 03/20/25 and 03/26/25 surveys effective 04/16/25. The census at the time of survey was 137 and the facility held a license for 140 beds.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/30/25