MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09FD	A. BUILDING: _____ B. WING _____	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOY DYER MANOR NH	1000 EAST MADISON HOUSTON, MS 38851

(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) at the facility on 11/22/21 for MS00018253 related to pressure ulcers, weight loss, feeding assistance and turning/respositioning. During the survey, the SA determined that the facility was in compliance with regulations for the Aged and Infirmed and was not able to substantiate the allegations related to pressure ulcers, weight loss, feeding assistance and turning/repositioning. Census at the time of the survey was 52 with a bed capacity of 66.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE