

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/08/2021
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) COMPLETE DATE
{M 000}	Initial Comments On 7/8/21 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the complaint investigation that was conducted on 6/17/21. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with both Federal and State requirements of participation.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/12/21