

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 11/14/2019
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 On November 14, 2019 the State Agency (SA) conducted an on-sight complaint investigation for a facility self-reported incident, CI MS #16330. The CI MS #16330 was unsubstantiated and no facility deficiencies were cited. The SA determined that the facility was in substantial compliance with the requirements for Medicaid and Medicare.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE