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 02/15/2022

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 A Complaint Investigation (CI) #18486 was conducted 2/14/22-2/15/22 for a complaint filed regarding allegations against Quality of Care (QOC)/Staffing, call lights not answered timely, Physical environment/sufficient supplies not available, QOC/ services not performed per POC and Physician, Resident Assessment, Resident left wet for extended periods, Residents not groomed adequately. The allegations were unsubstantiated with no deficiencies cited. During the survey, the facility was found to be in compliance with the requirements of the Mississippi Long Term Care Regulations. The facility has a license for 66 beds with a census of 44 at the time of survey.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/22