

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 11/09/2022
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 11/09/22 the State Agency (SA) conducted on site complaint investigation, MS00019444 for alleged neglect of a respite resident and for not providing oxygen ordered by the physician, and for over medicating a respite resident; and MS00019673 for alleged dirty floors, staff not wearing name tags, and diabetic diets not being honored. On 11/09/2022 the (SA) did not substantiate the allegations and no deficiencies were cited. The SA determined that the facility was in substantial compliance with the regulations for the Aged and Infirm. The facility census was 108 and the facility held a license for 152 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

11/22/22