

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30CD	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/17/2023
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF MOSS POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 MAIN STREET MOSS POINT, MS 39563		
(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 follow-up revisit at the facility on 7/17/23 related to an annual recertification survey that was conducted on 4/10/23 through 4/13/23. The SA found the corrective measures put in place by the facility corrected the deficiencies cited on the 04/13/23 survey effective 5/22/23. The SA is recommending the facility be placed in substantial compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement effective 6/7/2023, the compliance date of the 5/19/23 survey.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

07/31/23