

MSDH - Health Facilities Licensure and Certification

|                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                             |                                                                                                                          |                                                                |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>42PM</b>                                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>12/27/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RIVERVIEW NURSING &amp; REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1600 WEST CLAIBORNE AVENUE EXTENDED<br/>GREENWOOD, MS 38930</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {M 000}                                                                                  | <p>Initial Comments</p> <p>On 12/27/23 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the complaint survey that was completed on 11/09/23. The information provided by the facility confirmed the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 12/22/23.</p> | {M 000}                                                                                                     |                                                                                                                          |                                                                |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/27/23