

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/29/2024
NAME OF PROVIDER OR SUPPLIER RIVER HEIGHTS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 402 ARNOLD AVENUE GREENVILLE, MS 38701		
(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS The State Agency (SA) conducted a revisit at the facility on 05/29/24 and placed the facility back into compliance for F656 related to care planning and F689 related to accident hazards involving lift use. The facility was placed back into compliance as of 05/28/24. The census at the time of the survey was 52 and the facility held a license for 60 beds.	{F 000}			

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

Electronically Signed

TITLE

(X6) DATE

06/07/2024