

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>82MC</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>04 - MARTHA COKER GREEN HOUSE<br/>HOME</b><br>B. WING _____                | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R<br/>12/02/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MARTHA COKER GREEN HOUSE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2041 GRAND AVE<br/>YAZOO CITY, MS 39194</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 Comment</p> <p>On 12/02/24 the State Agency (SA) conducted a desk review of the information that was provided to our agency related to the annual survey that was conducted on 09/26/24. The information provided by the facility confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). The SA is recommending that your facility be placed back in compliance effective 11/29/24.</p> | {M 000}                                                                                 |                                                                                                                          |                                                              |

Mississippi State Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/02/24