

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>42PM</b>                                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/30/2024</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>The State Agency (SA) conducted a Complaint Investigation (CI MS #27212) at the facility on 12/30/24. Although there were no deficiencies cited related to the complaint investigation the facility remains out of compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements due to deficiencies cited on the 11/06/24 annual survey.</p> <p>The facility held a license for 91 beds, with a census of 64.</p> | M 000                                                                                                       |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE

Electronically Signed

01/06/25