

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/02/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  |                                                                                                       |                                                                                                                          |                                                                    |                            |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255252</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b> - <b>MAIN BUILDING 01</b><br><br>B. WING _____    |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/17/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MS CARE CENTER OF GREENVILLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1221 EAST UNION STREET</b><br><b>GREENVILLE, MS 38703</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>COMPLETION<br>DATE |
| {K 000}                                                                 | <b>INITIAL COMMENTS</b><br><br><p>On 03/17/25 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 02/04/25. 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 03/17/25.</p> |                                                                            |  | {K 000}                                                                                               |                                                                                                                          |                                                                    |                            |

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

TITLE

(X6) DATE

Electronically Signed

03/19/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.