

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 76WC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/03/2025
NAME OF PROVIDER OR SUPPLIER WASHINGTON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703			
(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey at the facility on 06/03/25. During the survey, the SA determined that the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm and cited no deficiencies. The census at the time of the survey was 54 with a bed capacity of 60.	M 000			

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

TITLE

(X6) DATE

Electronically Signed