

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/18/2025	
NAME OF PROVIDER OR SUPPLIER GREENE COUNTY HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451			
(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	
M0000	Initial Comments The State Agency (SA) conducted a follow-up revisit at the facility on 8/18/25 related to a complaint survey that was conducted on 7/24/25. The SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and recommends the facility be placed back into compliance effective 8/8/25.		M0000			08/22/2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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