

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WASHINGTON... B. WING	(X3) DATE SURVEY COMPLETED 04/28/2026	
NAME OF PROVIDER OR SUPPLIER WASHINGTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1920 LISA DRIVE EXTENDED , GREENVILLE, Mississippi, 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) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS 42 CFR 483.09 The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	K0000			
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the facility failed to maintain the fire alarm system in proper operating condition in accordance with NFPA 101, Section 9.6.1.3. This deficient practice affected the entire facility. Findings include: On 04/28/2026 at approximately 11:30 AM, observation revealed the facility's main fire alarm control panel displayed a trouble signal indicating: "Auxiliary Relay Disconnect T0001/0001." During activation of the fire alarm system, the following deficiencies were observed: Smoke barrier doors failed to release and close as designed. Exit doors failed to automatically release and	K0345			

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 reverse for further 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255314		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WASHINGTON... B. WING		(X3) DATE SURVEY COMPLETED 04/28/2026	
NAME OF PROVIDER OR SUPPLIER WASHINGTON CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1920 LISA DRIVE EXTENDED , GREENVILLE, Mississippi, 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) COMPLETION DATE
K0345 SS = F Bldg. 01	Continued from page 1 unlock, requiring use of the door release code to exit the facility. Further observation confirmed that audible and visual notification devices functioned as intended. The Maintenance Director verified that the fire alarm system successfully transmitted a signal to the monitoring company at approximately 12:14 PM on 4/28/26. The Administrator contacted the fire alarm service provider (Systronics) to schedule repairs. The Administrator further stated the facility would implement its Emergency Operations Plan (EOP), including initiation of a fire watch, until the system is restored to full functionality.			K0345			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255314		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/28/2026	
NAME OF PROVIDER OR SUPPLIER WASHINGTON CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1920 LISA DRIVE EXTENDED , GREENVILLE, Mississippi, 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) COMPLETION DATE
E0000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 04/28/26 revealed the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.			E0000			

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 reverse for further 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.

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