

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255217		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 05/05/2026	
NAME OF PROVIDER OR SUPPLIER RIVER HEIGHTS HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 402 ARNOLD AVENUE , GREENVILLE, Mississippi, 38701			
(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 record review, the facility failed to provide a properly maintained fire alarm system as required by NFPA 101, Section 9.6.1.3. This deficiency affected the entire facility on the day of survey. Findings include: On 5/5/26 at 11:00 AM, observation revealed the facility's main fire alarm panel displayed a trouble code indicating a fault on the tamper switch. The water-based fire protection and fire alarm systems remained operable. The facility notified the fire alarm company (Electronic Controls) and the sprinkler company (Holloway Fire Protection, LLC) to correct the deficiency. The findings were acknowledged by the Administrator and Maintenance Supervisor, who verified the observation during the exit interview on 5/5/26.			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
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E0000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 05/05/26 revealed the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.			E0000			

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