STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING _____ B. WING _____	C 01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	**1221 EAST UNION STREET 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) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and a Complaint Investigation (CI) #17998, #18049, #18249 and #18313 was conducted by the State Agency (SA) on 1/3/22 through 1/5/22. The facility was found to be in compliance with infection control regulations 42 CFR 483.73 related to E-0024(b)(6) and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. CI #17998 was unsubstantiated with no deficiencies cited for allegations of Quality of Care/care not provided per MD orders, Dietary Services/supplements not received as ordered, meals not timely, food not cooked, therapeutic diets not provided. CI #18049 was unsubstantiated with no deficiencies cited for allegations of Quality of Care/residents not groomed, resident safety, staffing and services not performed per plan of care. CI #18249 was unsubstantiated with no deficiencies cited for allegations against Dietary Services/meals not served timely, Therapeutic Diets and Sanitation. CI #18313 was unsubstantiated with no deficiencies cited for allegations of Quality of Care/not following MD orders, Dietary Services and Activities of Daily Living. The facility is licensed for 90 beds with a census of 77 at the time of survey.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2022

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.