

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 R-C 05/11/2021
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 CI MS #16704, CI MS #16966, CI MS #17141, CI MS #17217, CI MS #17244, CI MS #17330, CI MS #17368, CI MS #17499 & CI MS #17639 A desk review was conducted on 5/11/2021. The facility is in substantial compliance as of 5/7/2021.	M 000			

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

TITLE

(X6) DATE