

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

PRINTED: 04/28/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                          |                            |                                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255217</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>04/19/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RIVER HEIGHTS HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>402 ARNOLD AVENUE</b><br><b>GREENVILLE, MS 38701</b>                         |                            |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                        |
| F 000                                                                      | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted a facility reported incident complaint survey, CI MS #18658 at the facility from 04/18/2022 to 04/19/2022 and a Complaint Survey for CI MS #18702. During the survey, the SA did not substantiate noncompliance with MS #18658 FRI related to resident/Patient/Client Abuse or MS #18702 related to physical environment /equipment not working beds and door, quality of care facility staffing, and care not performed per physician orders. The facility remains out of compliance with the requirements for participation in Medicare and Medicaid due to deficiencies cited on the 03/11/2022 survey. The facility was licensed for 60 beds and had a census of 37 at the time of the survey.</p> | F 000                                                                      |                                                                                                                          |                            |                                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/27/2022

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.