

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14GI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/28/2021
NAME OF PROVIDER OR SUPPLIER GREENBOUGH HEALTH AND REHABILITATION CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614		
(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 The State Agency (SA) conducted a complaint survey from 9/27/21 through 9/28/21 for MS CI #18044 and MS CI #18057. The SA did not substantiate complaints MS #18044 for physical environment for offensive odors and cleanliness, quality of care related to resident with body odor and responsible party not notified of resident change in condition and MS CI #18057 for injury of unknown origin and quality of care related to facility staffing. During the survey the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited. The census was 52 with 60 beds.	M 000		

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

TITLE

(X6) DATE