

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 R 02/22/2023
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 On 2/22/23 the State Agency (SA) conducted a follow up survey for the annual survey conducted on 1/11/23. During the survey, the SA determined that the facility was compliance with the requirements of with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. . The SA is recommending that your facility be placed back in compliance effective 2/9/23. The census at the time of the survey was 58 with a bed capacity of 62 beds.	{M 000}		

Mississippi State Department of Health

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

TITLE

(X6) DATE