

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 04/16/2024
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 Investigation (CI MS# 24439) at the facility from 04/15/2024 through 04/16/2024. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated resident choices, and menus, with no deficiencies cited. The facility held a license for 60 beds, with a census of 57.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

05/03/24