

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 03/24/2025
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 03/24/25 the State Agency (SA) conducted an on site complaint investigation (CI) for MS28320 for alleged abuse. The SA did not substantiate the allegation and no deficiencies were cited. The SA determined that the facility was in substantial compliance with the requirements for The Aged and Infirm. However, the facility remains out of compliance due to deficiencies cited on the 02/26/2025 survey. The facility census was 59 and the facility held a license for 60 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/14/25