STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255294	A. BUILDING _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBOUGH HEALTH AND REHABILITATION CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS# 28450, CI MS# 28614, CI MS# 28894, CI MS# 28902 and CI MS# 29000) at the facility from 5/20/25 through 5/21/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F689 for CI MS# 29000 for failure to put safety measures in place to prevent an accident . There were no deficiencies cited for CI MS# 28450, CI MS# 28614, CI MS# 28894, or CI MS# 28902. The census at the time of the survey was 55 with a bed capacity of 62 beds.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to put safety measures in place to prevent an accident during van transport for one (1) of three (3) residents reviewed. Resident #1. Findings Include: Record review of "Instructions for loading and unloading a resident with a wheelchair lift on a	F 689	1. Resident #1 was transferred to the hospital by Emergency Medical Services and assessed for injuries. There were no injuries noted and resident # 1 was transferred back to the facility at 4:45pm on May 2 ,2025. The resident representative of resident # 1 was notified at 10:22am on May 2, 2025, and the resident's physician was notified at	6/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/29/2025

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F 689	Continued From page 1 transport vehicle", provided by the Administrator, revealed "Securing the resident in the vehicle. Secure vehicle supplied safety seat belt around the resident." Interview with the Staff Development Nurse on 5/21/25 at 12:15 PM, she verified that the facility did not have a policy on accident prevention or van transport. Record review of the facility investigation revealed on 5/2/25, during transportation to a physician's appointment Resident #1 fell from the wheelchair on to the van floor. Emergency Medical Services (EMS) was contacted, and the resident was transferred to the local emergency room. Resident #1 had no injuries and was transported back to the facility. Record review of Resident #1's hospital records dated 5/2/25 revealed that she sustained no injuries and no treatment was required. An interview with Certified Nursing Assistant (CNA) #1 on 5/21/25 at 12:05 PM, she stated that on 5/2/25 she was transporting Resident #1 from the nursing home to a physician's office approximately two (2) hours away from the facility. She stated when she stopped at a red light down the street from the doctor's office, she checked her rearview mirror and did not see the resident. She stated she drove to where she could pull over to check on the resident and noticed that she was lying on her side on the floor. CNA #1 stated that she was unsure how long the resident had been on the floor of the van. She stated the resident responded to her and she was instructed by the Director of Nursing to call EMS. She stated that EMS arrived and	F 689	10:35am on May 2, 2025. On May 2, 2025, CNA# 1 received education by the Director of Environmental Services regarding Safe Driving and Parking, Basics of Defensive Driving, Transport Vehicle Lift Operation, and Providing Safe Transportation policies. 2. The van was inspected upon arrival to the facility by the Director of Environmental Services to ensure that seat belts are in place and secure. All residents that are transported on the van by wheelchair have potential to be affected. 3. On April 22, 2025, designated facility van drivers received education by the Director of Environmental services regarding, Defensive Driving Basics, Transport Vehicle Lift Operation, Providing Safe Transportation polices. Designated Van drivers were not allowed to drive the van until the education was completed. Newly hired van drivers will be educated during orientation prior to being able to drive the van. 4. The Quality Assurance Performance Improvement Committee (QAPI) met on 5/2/25 to review Van Safety Policies, Accident and Incident Policy and a plan to ensure residents safe transportation in the van. The Maintenance Director began using a Risk Management Quality Improvement Monitoring Tool On May 19, 2025, to ensure safe transportation weekly times four weeks then every two weeks times four weeks then monthly	

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F 689	Continued From page 2 transported the resident to the local emergency room. CNA #1 stated that the resident must have slid out of the wheelchair and admitted that the seat belt was not buckled. She stated that she secured the wheelchair to the van but confirmed that she did not put the safety seat belt around the resident. An interview with the Administrator and Director of Nursing (DON) on 5/21/25 at 12:10 PM, they verified that CNA #1 did not put the safety seat belt around the resident, and it was their expectation that she would have. They agreed that failure to apply the seat belt could result in injuries. Record review of the "Admission Record" revealed that the facility admitted Resident #1 on 4/18/25 with diagnoses including Acquired Absence of Left Leg Below Knee.	F 689	times three months. The results from the monitoring will be reviewed by the Executive Director starting on June 1, 2025, and presented to the QA committee on June 19, 2025 for a period of 3 months until issue is resolved. Changes will be made to the plan of correction as needed to maintain substantial compliance. 5. Completion date 6/20/25.	