

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2021  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255294</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                   |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/28/2021</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBOUGH HEALTH AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>340 DESOTO AVE EXTENDED</b><br><b>CLARKSDALE, MS 38614</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                                                  | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted a complaint survey 9/27/21 through 9/28/21. During the survey, the SA determined that the facility was in compliance with the requirements of the participation of Medicare and Medicaid. The SA did not substantiate MS CI #18044 for physical environment of offensive odors and cleanliness, quality of care related to resident with body odors and responsible party not being notified of resident change of condition and MS CI #18057 for injury of unknown origin and quality of care related to facility staffing and no deficiencies were cited. Census was 52 with 60 beds.</p> |                                                                            |  | F 000                                                                                                  |                                                                                                                          |                                                                    |                            |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  | TITLE                                                                                                  |                                                                                                                          | (X6) DATE                                                          |                            |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.