STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	**1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451**

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 1/20/26 through 1/22/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid cited F550, F628, F695, and F812. The facility had a census of 49 and was licensed for 60 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to dignity by not covering a urinary catheter drainage bag for one (1) of (18) sampled residents, Resident #13. Findings include: A review of the facility's policy, "Catheter Care" (undated) revealed, "…It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use…Policy Explanations…2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use…" A review of the facility's policy, "Resident Rights", dated 02/2021, revealed, "…Employees shall treat all residents with…dignity. Policy Interpretation and Implementation 1. …These rights include the resident's right to: a. a dignified existence…" A record review of the "Admission Record" revealed the facility admitted Resident #13 on 3/3/25 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/10/25, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated her cognition was moderately impaired. A record review of the "Order Listing Report" revealed Resident #13 had a Physician's Order, dated 12/29/25, for catheter care every shift and as needed. On 01/20/2026 at 11:59 AM, during an observation and interview, Resident #13 was lying in bed with an	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0550 SS = D	Continued from page 2 indwelling urinary catheter drainage bag hanging on the side of the bed, uncovered and visible to anyone when the resident's door was opened. Resident #13 stated she did not know why she had a urinary catheter. On 01/20/2026 at 12:05 PM, during an observation and interview Registered Nurse (RN) #2, she confirmed that Resident #13's urinary catheter drainage bag was exposed and not covered. RN #2 confirmed the catheter drainage bag should have been covered for resident dignity. On 01/21/2026 at 4:07 PM, during an interview, the Director of Nursing (DON), stated Resident #13 had an indwelling catheter since 12/28/2025. She explained wound care staff were responsible for catheter placement and changes. The DON confirmed staff were required to keep catheter drainage bags covered for dignity, and this expectation was reviewed during catheter care in-service training completed within the last year. She stated her expectation was for staff to ensure catheter drainage bags were covered at all times. On 01/22/2026 at 2:01 PM, during an interview, the Administrator stated she expected staff to place all catheter drainage bags in privacy covers to maintain resident dignity.	F0550		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0628 SS = D	Continued from page 3 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0628 SS = D	Continued from page 4 paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0628 SS = D	Continued from page 5 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0628 SS = D	Continued from page 6 must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide written notification of a resident transfer that included the specific reason for the transfer in a language and manner the resident's representative could understand for one (1) of two (2) residents sampled for hospitalization. Resident #49. Findings include: A review of the facility's policy, "Transfer and Discharge (including AMA - Against Medical Advice (AMA)," revised 2025, revealed, "…Definitions: … 'Transfer and Discharge' includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not… Policy Explanation and Compliance Guidelines: … 3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all the following at the time it is provided: a. The specific reason and basis for transfer or discharge…" A record review of the "Admission Record" revealed the facility admitted Resident #49 on 9/15/24 and he had current diagnoses including Schizoaffective Disorder, Bipolar Type. A record review of the "Discharge Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 1/4/26 revealed Resident #49 had an unplanned discharge to an acute hospital with return anticipated on 1/4/26.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0628 SS = D	Continued from page 7 A record review of the resident's "Progress Notes" revealed, "…Effective Date 1/4/26 3:16 AM… Note Text: sent to (proper name of the local acute care hospital) ER (Emergency Room) for evaluation r/t r(elated to) low O2 (oxygen) sats (saturations) and elevated temp (temperature…" A record review of the "Notice of Resident Transfer or Discharge", dated 1/5/26, revealed Resident #49 was transferred to the local acute care hospital on 1/4/26 and listed the reason as "Resident has transferred to the hospital/home with the anticipation of return…" It did not indicate the clinical reason for the transfer. A record review of the resident's "Progress Notes" revealed, "…Effective Date 1/4/26 8:15 PM… Note Text: resident disoriented, aroused with sternal rub. shows difficulty swallowing meds (medications)…ordered for resident to sent to (proper name of a neighboring county acute care hospital – different facility from earlier transfer) for further treatment…" A record review of the "Notice of Resident Transfer or Discharge", dated 1/5/26, revealed Resident #49 was transferred to an acute care hospital in a neighboring county on 1/4/26 and listed the reason as "Resident has transferred to the hospital/home with the anticipation of return…" It did not specify the clinical reason for the transfer. On 1/22/26 at 2:30 PM, during an interview, the Business Office Manager reported Resident #49 was sent to the hospital twice on 1/4/26, which resulted in (2) transfer letters for that date. She reported she mailed the written notices to the resident's representative. She confirmed the notification did not list the specific reason for the transfer and stated she was not aware the specific reason was required to be included on the notices and checked only the general reason category on the letters. On 1/22/26 at 3:00 PM, during an interview, the Administrator reported she was not aware of the specific federal requirements for written notification of resident transfers. She stated her expectation was for staff to follow federal requirements for notice of transfers.	F0628		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0695 SS = D	Continued from page 8 care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide respiratory care in accordance with physician orders and professional standards of practice by not administering oxygen at the ordered flow rate and by not documenting as-needed (PRN) oxygen administration for one (1) of (1) resident reviewed for respiratory care, Resident #2. Findings include: A review of the facility's policy, "Oxygen Administration Policy," (undated) revealed, "…Oxygen is administered to residents who need it in, consistent with professional standards of practice…Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician…3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy…" On 1/20/26 at 12:09 PM, during an observation, Resident #2 was observed lying in bed with oxygen via nasal cannula (nc) running at two (2) liters per minute. On 1/20/26 at 12:22 PM, during an observation and interview, Licensed Practical Nurse (LPN) #1 who was the floor nurse for Resident #2, observed Resident #2's oxygen concentrator running at (2) liters per minute. She confirmed the setting and reported the setting did not align with the physician's order, which was three (3) liters per minute. On 1/21/26 at 12:13 PM, during an interview, Registered Nurse (RN) #1 explained it was the responsibility of the primary nurse, or floor nurse to monitor residents' oxygen flow rates and oxygen saturation levels. On 1/21/26 at 4:07 PM, during an interview, the Director of Nursing (DON) reported it was the responsibility of the floor nurse to ensure Resident #2's oxygen was administered at the physician-ordered rate. She reported medication nurses could also check	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0695 SS = D	Continued from page 9 oxygen settings during medication passes. She further reported the purpose of following physician orders was to maintain appropriate oxygen saturation levels and stated her expectation was for staff to verify oxygen flow rates during medication passes. On 1/22/26 at 2:45 PM, during an interview, the Administrator reported she had been advised that Resident #2's oxygen concentrator had been observed running at (2) liters per minute on 1/20/26 and that the physician order required (3) liters per minute. She stated the oxygen adjustment knob could be easily bumped but emphasized nursing staff were expected to routinely check oxygen flow rates to ensure consistency with physician orders and stated her expectation was for staff to always follow physician orders for prescribed oxygen levels. A record review of the "Admission Record" revealed the facility admitted Resident #2 on 4/22/22 and she had current diagnoses including Hemiplegia and Hemiparesis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated her cognition was moderately impaired. A record review of the "Order Listing Report" revealed Resident #2 had an active Physician's order, dated 7/18/24, for oxygen at (3) liters per minute as needed for shortness of breath or oxygen saturation less than 92%. A record review of the January 2026 "Medication Administration Record (MAR)" revealed no documentation indicating Resident #2 received PRN oxygen on 1/20/26, although the resident was observed wearing oxygen via nasal cannula.	F0695		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0812 SS = F	Continued from page 10 local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to maintain safe food handling and storage practices by not removing expired food items from the refrigerator and freezer and by not dating and labeling opened and repackaged food items for one (1) of three (3) days of survey. Findings include: A review of the facility's policy, "Food Receiving and Storage," revised 11/2022, revealed, " "Foods shall be received and stored in a manner that complies with safe food practices…Refrigerated/Frozen Storge 1. All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date)…7. Refrigerated foods are labeled, dated and monitored so they are used by their "use-by" date, frozen, or discarded…" On 1/20/26 at 10:01 AM, during an observation and interview, the reach-in refrigerator #2 was observed to contain opened, repackaged sliced bologna sandwich meat labeled with an "opened" date of 10/8/25 and a best-by/use-by date of 11/8/25, which had expired. Reach-in refrigerator #2 was also observed to contain several packages of opened, repackaged sliced white cheese without an open date labeled and sliced American cheddar cheese that had been opened and repackaged without an open date labeled on the outside of the clear plastic bags. A container of French's mustard was observed opened, in use, and stored unrefrigerated on a shelf despite manufacturer instructions indicating the product should be refrigerated after opening. During the interview, the Dietary Supervisor acknowledged the expired and improperly labeled food items and reported it was the responsibility of all dietary staff to routinely check dates in refrigerators and freezers and	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET , LEAKESVILLE, Mississippi, 39451

(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
F0812 SS = F	Continued from page 11 to remove expired food items. On 1/22/26 at 2:50 PM, during an interview, the Administrator reported her expectation was for the dietary department to conduct routine weekly monitoring to ensure expired foods were identified and removed in a timely manner and foods were refrigerated as required. She stated both the Dietary Manager and Dietary Supervisor were responsible for oversight of food storage and safety practices. She further reported that while all staff were encouraged to check product dates when handling food items, the primary responsibility for monitoring expiration dates and proper labeling rested with the Dietary Manager and Dietary Supervisor to ensure compliance with food safety standards and to prevent the use of expired or improperly labeled food products.	F0812		