

Mississippi State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>02/17/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>GREENBOUGH HEALTH AND REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                       |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>340 DESOTO AVE EXTENDED , CLARKSDALE, Mississippi, 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<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |  |
| M0000                                                                              | Initial Comments<br><br>The State Agency (SA) conducted three (3) Complaint Investigations (CI MS #2735881, CI MS #2736216, and CI MS #2736246) at the facility on 2/17/26. During the survey, the SA determined that the facility was in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited.<br><br>The census at the time of the survey was 54 with a bed capacity of 60 beds. |                                                       | M0000               |                                                                                                                          |  |                                                 |  |

Office of Primary Care and Health Systems Management

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