

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Greene Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2402 Country Club Road Paragould, AR 72450	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interviews, facility document review, and facility policy review, it was determined that the facility failed to conduct a thorough self-assessment of the facility staffing required for day/evening/night coverage, the competencies and training of the staff, formulate a plan for staff recruitment and retention, conduct community-based risk analysis identifying the potential natural disasters, to meet the needs of the residents when completing their facility assessment. The findings include: A review of the undated Facility Assessment revealed on 01/05/2026, a spreadsheet with Minimum Data Set (MDS) resident information, which contained admission and discharge data, resident identified diagnoses, resident activities of daily living assistance level, and medication and the services required to treat those diagnoses. Below each section were instructions on how to apply the data when the facility developed their Facility Assessment. The Facility Assessment did not address: staffing needs required to care for the residents on a day-to-day basis including; day/evening/nights and emergencies, any certified or licensed staff and skills sets required to provide the level of care, staff education/training and competencies required to provide the care, a recruitment and retention plan for staff, a facility based and community-based risk assessment, or include active involvement of the Director of Nursing (DON), direct care staff, resident, or resident representatives. During an interview on 01/08/2026 at 9:17 AM, the DON stated the Medicare Director gathered the information for the Facility Assessment and the Administrator filled it out. During an interview on 01/08/2026 at 9:45 AM, the Medicare Director stated the facility used a third-party system in which they uploaded resident MDS information to generate numbers. She then went through it to look at any special things like a resident's religion, preferences for activities, and competencies, which were all ongoing. When asked about identified staffing needs the Medicare Director stated there was no staffing information for shifts or type of nursing staff, it was just a spread sheet of generated data. During an interview on 01/08/2026 at 10:58 AM, the Administrator stated the Facility Assessment was to gauge the needs of the facility as far as staff; what kind of training they needed and the residents needed, and that it should be an individualized assessment of the facility that was tailored to the facility, and not generic. There was no staffing in the Facility Assessment, and the competency just always showed in progress. Recruitment was not considered in the facility assessment, and it did not address any emergency preparedness in the facility assessment. The Administrator stated the Medicare Director was not the main component for compiling the Facility Assessment, and there were no bedside staff or resident involvement, it was a management thing. The information was from the (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents' MDSs, which then produced the spreadsheet data form. During an interview on 01/07/2026 at 4:23 PM, the Administrator stated the facility did not have a policy for Facility Assessment.		