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	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbough Health and Rehabilitation Center	340 Desoto Ave Extended Clarksdale, MS 38614

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure resident trust fund withdrawals were safeguarded from misappropriation, when resident funds were withdrawn without documentation verifying goods or services were provided, for two (2) of 40 residents with trust fund accounts. (Residents #5 and #49). Findings Included: Record review of the facility policy titled Abuse, Neglect and Exploitation revealed, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property.Resident # 5 An interview with Resident #5 on 1/6/26 at 9:02 AM, she stated that $700.00 was taken out of her trust fund account in May of 2025. She verified that she signed the Resident Trust Fund Withdrawal form but received no goods or services in return. She stated that the facility did replace the money that had been taken out of her account. She further stated that she receives a quarterly trust fund statement. Record review of the Resident Trust Fund Withdrawal form, dated 5/15/25, for Resident #5 indicated that she signed for $700.00 to be withdrawn for personal use. The form listed the Receptionist as the Fund Custodian. An interview with Activities Director on 1/6/26 at 9:38 AM, she stated that the Business Office Manager (BOM) #1 instructed her that Resident #5 needed to withdraw money from her trust fund for personal use. She stated she completed the Resident Trust Fund Withdrawal form, obtained the resident signature and retuned the form to BOM #1. She stated that she is usually the one who takes residents shopping or shops for them, but that she had not done this in May 2025 for Resident #5. She further stated that she was not aware of what the money was spent on. Resident # 49 An interview with Resident # 49 on 1/6/26 at 9:55 AM, he verified money had been taken out of his trust fund account but was unsure how much it was or when it was. He indicated that he did sign the Resident Trust Fund Withdrawal form but did not recall receiving any goods or services in return. He also verified that the facility replaced the money that was removed and that he receives a quarterly trust fund statement. Record review of the Resident Trust Fund Withdrawal form, dated 7/1/25, for Resident #49 indicated that he signed for $1115.00 to be withdrawn for other: cash advance. The form listed the facility Receptionist as the Fund Custodian and was witnessed by Transporter #1 and Transporter #2. Further review of Resident Trust Fund Withdrawal form, dated 7/23/25, for Resident #49 indicated that he signed for $1700.00 to be withdrawn for other: cash advance. The form listed Receptionist as the Fund Custodian and was witnessed by Certified Nursing Assistant (CNA) #3 and the Maintenance Man. An interview with the Receptionist on 1/6/26 at 10:04 AM, she stated that the BOM is her supervisor. She stated that the BOM would notify her when the resident needed to withdraw money from their trust fund and what it was for. She stated she was responsible for filling out the Resident Trust Fund Withdrawal form, explaining what the withdrawal was for, and getting the resident signature. She then turns the form into the BOM who withdraws the money. She verified (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that two (2) witnesses are required if the resident has difficulty signing. She stated that on 7/1/25 and 7/23/25 that BOM #1 told her that Resident #49 was withdrawing the money to spend down his account so that he was not over the resource limit for Supplemental Security Income (SSI). She stated that she was unsure what the money was spent on.An interview with CNA #3 on 1/6/26 at 10:33 AM, she verified that she witnessed Resident #49 sign the Resident Trust Fund Withdrawal form on 7/23/25. She stated that she was not aware of what the money was spent on. Record review of the initial audit performed by the facility and corporate office on 9/25/25 indicated that $1115.00 was withdrawn from Resident #49's' account on 7/1/25 and $1700.00 was withdrawn from his account on 7/23/25 with no receipt and the check made out to [Proper name of the facility].Further record review of the initial audit performed by the facility and corporate office indicated that $700.00 was withdrawn from Resident #5's account on 5/15/25 with no receipt and the check made out to [Proper name of the facility]. An interview with BOM #2 on 1/7/26 at 9:00 AM, she stated that she had received a letter from the Social Security Administration on 9/18/25 for a resident indicating that the resident's income exceeded the resource limit for SSI and it prompted her to initiate an audit of resident trust fund accounts beginning 9/22/25 to 9/24/25. She indicated this audit identified withdrawals from the resident's trust fund account with no receipts of where the money went. BOM #2 stated that if the resident wishes to withdraw money from their account or needs to spend down their account she informs the receptionist who completes the Resident Trust Fund Withdrawal form, obtains the resident's signature, with witnesses if required, and returns the form to her. She then enters the information into the computerized resident fund management service, indicating what the transaction is for and a check is generated. She further explained that the facility has specific persons who are allowed to sign the checks, and two (2) signers are required. A third employee will take the check to the bank to be cashed, and the money is brought back to the facility and secured until it is given to the resident or sent with the Activity Director for shopping. She stated that receipts are returned to her so she can reconcile what was withdrawn with what was spent. She verified there were no receipts for the 5/15/25 withdrawals from Resident #5's account or the 7/1/25 and 7/23/25 withdrawals from Resident 49's account.An interview with the Administrator (ADM) 1/7/26 at 9:25 AM, he stated that after receiving a letter from the Social Security Administration for a resident indicating that the resident's income exceeded the resource limit for SSI the BOM #2 notified him and the corporate office for a full audit of the resident trust fund accounts. He verified the audit identified unauthorized withdrawals and/or withdrawals lacking supporting documentation from resident trust fund accounts. He stated the facility identified BOM #1 as the alleged perpetrator at the time of the withdrawals. The ADM confirmed affected residents required reimbursement due to missing funds. ADM verified that BOM #1 was terminated from her employment at the facility on 7/31/25. An interview with the ADM on 1/7/26 at 12:00 PM, and a record review of the facility investigation, audits, in-service sign in sheets and trust fund deposit record verified that on 9/22/25 - 9/24/25 an investigation and audit was performed to determine if withdrawal of funds from resident's trust fund accounts were either not authorized by resident or responsible party or lacked supporting documentation for the withdrawal. The facility replaced funds for any residents with discrepancies in their accounts. Responsible parties of each resident identified were notified by nursing staff on 9/24/25. Education was provided on 9/24/25 to the BOM, the Activity Director, and the ADM on the policy and procedures for resident trust in relation to resident shopping and spend downs by the regional Business Office Manager. All facility staff received education on Abuse and Neglect with an emphasis being placed on misappropriation of funds/residents rights which began on 9/24/25. Affected residents were reimbursed on 10/8/25. A follow-up (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the ADM on 1/8/26 at 9:05 AM, confirmed that the incident and investigation results were presented to the Quality Assurance Committee on 9/24/25, during which the facility policy was reviewed with no revisions made and the facility continued to monitor all transactions monthly.Record review of the admission Record revealed the facility admitted Resident #5 on 5/3/19 with a diagnosis of Acute on Chronic Diastolic (Congestive) Heart Failure. Record review of the Brief Interview for Mental Status dated 10/9/25 indicated that Resident # 5 was cognitively intact. Record review of the admission Record revealed the facility admitted Resident #49 on 4/28/23 with a diagnosis Systemic Lupus Erythematosus.Record review of the Brief Interview for Mental Status dated 10/24/25 indicated that Resident # 49 was cognitively intact.Based on the implementation of the facility's corrective actions on 10/8/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 10/9/25, prior to the State Agency (SA) entrance into the facility on [DATE].Validation:The SA validated on 1/8/2026, through interview and record review that all corrective actions had been implemented as of 10/8/25, and the facility was in compliance as of 10/9/25, prior to the SA's entrance on 1/5/26.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement comprehensive, person-centered care plans to address residents identified Activities of Daily Living (ADL) and skin integrity needs. The facility failed to develop a care plan related to nail care for (Residents #2, #21, and #24); failed to implement the care plan related to grooming and dressing (Resident #21); and failed to develop a care plan related to pressure ulcer prevention (Resident #4) for four (4) of 21 resident care plans reviewed. Findings include: Review of the facility policy titled Comprehensive Care Plan with a review date of 11/14/2025, revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Resident #2 On 1/5/2026 at 11:05 AM, during initial rounds Resident #2 was observed lying in bed wearing a hospital gown with approximately one-half of an inch (1/2) in length nails with jagged edges and a thick, brown substance underneath. During an interview on 1/7/2026 at 11:45 AM, the Minimum Data Set (MDS) Coordinator confirmed that the care plan was not developed to include nailcare as part of their daily care. She stated that the care plan is developed and implemented for the resident based on his/her care needs and that nail care should have been included in his care plan. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Dementia. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 1/02/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 06, indicating the resident had severely impaired cognition. Resident #4 Record review of the care plan revealed Resident #4 .refused to be turned or repositioned every two (2) hours because it interferes with me watching T.V. The care plan did not include interventions to prevent the development of pressure ulcers. Review of the Wound-Weekly Observation Tool, dated 8/18/25, revealed Resident #4 developed a suspected deep tissue Injury (SDTI) to the left (L) heel measuring 60 millimeters (mm) length x 50mm width x 1mm depth on 8/18/25. Record review of the Task List Report revealed the task for off-loading of extremities was not (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	initiated until 12/10/2025. During an interview on 1/6/2026 at 2:15 PM, the MDS Nurse confirmed that the care plan was not developed to include off-loading of extremities to prevent pressure ulcers from developing on the heels. She stated the purpose of the care plan is to guide staff in providing individualized care to residents. On 1/6/2026 at 2:45 PM, during an interview the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that preventative measures were not implemented until 12/10/25. The DON stated her expectation was that preventative measures be implemented prior to the development of pressure ulcers. Record review of the admission Record revealed Resident #4 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Type 2 Diabetes Mellitus with Hyperglycemia, and Peripheral Vascular Disease, Unspecified. Record review of the quarterly MDS with an ARD of 11/10/2025 revealed under Section C a BIMS score of 01, indicating the resident had severely impaired cognition. Resident #21 Record review of Resident #21's Care Plan revealed an ADL self-care performance deficit related to confusion with interventions including extensive assistance of one person physical assist for bathing/hygiene/dressing. On 1/5/2026 at 10:31 AM, during initial rounds Resident #21 was observed lying in bed wearing a hospital gown with a dried, brownish substance on the top right side of the gown, approximately softball-sized, consistent in appearance with food or possible emesis. The resident also had visible scattered dark hair on her chin and long fingernails, approximately three-fourths of an inch (3/4) in length, with jagged edges. During an interview on 1/7/2026 at 2:51 PM, the MDS Coordinator confirmed that the care plan was not developed to include nailcare as part of their daily care nor was the Activities of Daily Living (ADLs) care plan implemented related to grooming and dressing. She further stated the purpose of the care plan is to guide the staff how to best provide care for the residents. Record review of the admission Record revealed Resident #21 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly MDS with an ARD of 11/18/2025 revealed under Section C a BIMS score of 00, indicating the resident had severely impaired cognition. Resident #24 On 1/5/26 at 11:00 AM, observation of Resident #24 revealed that her fingernails on both hands were approximately one-fourth (1/4) inch past her fingertips and jagged. Record review of Comprehensive Care Plan revealed no nail care plan of care was developed for the (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	trimming and/or cleaning of fingernails. During an interview on 1/7/2026 at 2:51 PM, the MDS Coordinator confirmed that the care plan was not developed to include nail care as part of their daily care. She further stated the purpose of the care plan is to guide the staff how to best provide care for the residents. Record review of the admission Record revealed that the facility admitted Resident #24 on 5/11/24 with a diagnosis of Cognitive Communication Deficit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents who required assistance received grooming and personal hygiene, including nail care (Resident #2, 21 and 24) and cleanliness of clothing (Resident #21) for three (3) of 50 residents observed for activities of daily living (ADLs). Findings Include: Review of facility policy titled Activities of Daily Living (ADLs), with a review date of 11/7/2025, revealed, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. Resident #2 During initial rounds on 1/5/2026 at 11:05 AM, Resident #2 was observed lying in bed wearing a hospital gown with approximately one-half of an inch (1/2) in length nails with jagged edges and a thick, brown substance underneath. During an interview and observation on 1/6/2026 at 10:35 AM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that the Certified Nursing Assistants (CNA)s are responsible for ensuring residents nails are kept clean, and the nurse is responsible for trimming his nails. Record review of the admission Record revealed Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Dementia. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/02/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 06, indicating the resident had severely impaired cognition. Resident #21 During initial rounds on 1/5/2026 at 10:31 AM, Resident #21 was observed lying in bed wearing a hospital gown with a dried, brownish substance on the top right side of the gown, approximately softball-sized, consistent in appearance with food or possible emesis. The resident also had visible scattered dark hair on her chin and long fingernails, approximately three-fourths of an inch (3/4) in length, with jagged edges. During an observation and interview on 1/5/2026 at 11:38 AM, CNA #1 confirmed Resident #21's gown had a dried, brownish substance on the top right side consistent in appearance with food or possible emesis, visible dark hair on her chin, and long, jagged fingernails. CNA #1 stated that Resident #21 typically had more facial hair than was present at the time, stating, She must have been shaved recently because there are usually lots more. During an interview on 1/6/2026 at 3:53 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that CNAs are responsible for ensuring residents receive assistance, or total care if needed, with ADLs each morning, including bathing or hygiene care as needed, dressing, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and grooming. The DON stated residents should not be left with visible grooming concerns, including soiled clothing, unaddressed facial hair, or long, jagged fingernails. She further stated that long, jagged fingernails pose a potential risk for infection related to skin tears and that wearing soiled clothing and female residents having unwanted facial hair are dignity concerns. Record review of the admission Record revealed Resident #21 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Other Seizures, Unspecified Mood (Affective) Disorder, Pseudobulbar Affect, and Moderate Intellectual Disabilities. Record review of the quarterly MDS with an ARD of 11/18/2025 revealed under Section C a BIMS score of 00, indicating the resident had severely impaired cognition. Resident #24 Observation of Resident #24 on 1/5/26 at 11:00 AM, revealed that her fingernails on both hands were approximately one-fourth (1/4) inch past her fingertips and jagged. Interview with CNA #2 on 1/5/26 at 11:36 AM, she verified that Resident #24 had long jagged nails and she stated that she thought the shower team was responsible for cutting nails. Interview with the DON she stated that the shower aid is responsible for nail care on shower days, but if the resident refused a shower the floor CNA should have cut the nails. She agreed that the nails were long and put Resident #24 at risk for injury. Record review of the admission Record revealed that the facility admitted Resident #24 on 5/11/24 with a diagnosis of Cognitive Communication Deficit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident responsible party interview, record review, and facility policy review the facility failed to ensure a resident received necessary care and treatment to maintain the highest practicable level of well-being by failing to obtain physician orders for wound dressings identified upon admission (Resident #16) for one (1) of 21 residents reviewed for skin and wound concerns. Findings Include: Review of the facility policy titled Provision of Quality Care with no revision date revealed, Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Resident # 16 Observation on 01/05/26 at 11:45 AM revealed the Resident #16 had an undated dressing located on the left upper arm. Record review of the admission Record revealed the facility re-admitted Resident #16 to the facility on [DATE] with a diagnosis of Acute Respiratory Failure with Hypoxia. Record review of a General Progress Note dated 12/30/25 revealed .Resident has pressure dressing to left upper arm . Record review of December 2025 and January 2026 Order Summary Report revealed no physician order for a dressing or treatment to the resident's left upper arm. Interview with Licensed Practical Nurse (LPN) #1 on 01/05/26 at 11:48 AM, confirmed the dressing was not dated and she was unsure why the dressing was present on the left upper arm of the resident. LPN #1 stated that the resident's family reported the dressing may have been placed there during her recent hospital stay, when staff attempted to start intravenous (IV) fluids. Interview with the Registered Nurse (RN) #1 on 01/05/26 at 11:50 AM, confirmed there were no orders for a dressing to the resident's left upper arm. RN #1 was unsure why the dressing remained in place or how long it had been present. Telephone interview with Resident #16's Resident Representative (RR) on 01/05/26 at 2:08 PM, he confirmed that during a hospitalization in December 2025, prior to re-admission, hospital staff attempted IV access to the resident's left upper arm, which resulted in bleeding and placement of a dressing. Interview with the Director of Nursing (DON) on 01/05/26 at 2:15 PM, she confirmed the dressing should have been removed and the left arm assessed upon admission to determine the condition of the skin and orders obtained for care. The DON stated failure to remove the dressing or assess the resident's arm could have resulted in skin breakdown or infection.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and facility policy reviews, the facility failed to ensure the prevention of an avoidable pressure injury for one (1) of seven (7) residents with pressure ulcers, (Resident #4), and delayed treatment for one (1) of seven (7) residents with pressure ulcers. (Resident #58) Findings include: Review of facility policy titled Pressure Injury Prevention and Management, with a review date of 11/7/2025, revealed, Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Resident #4 Review of the Wound-Weekly Observation Tool, dated 8/18/25, revealed Resident #4 developed a suspected deep tissue Injury (SDTI) to the left (L) heel measuring 60 millimeters (mm) length x 50mm width x 1mm depth on 8/18/25. Review of the Wound-Weekly Observation Tool, dated 10/2/25, revealed the SDTI to left (L) heel had progressed to a Stage 3 pressure ulcer measuring 60mm length x 50mm width x 1mm depth, intact and mushy. Review of the care plan revealed Resident #4 .refused to be turned or repositioned every two (2) hours because it interferes with me watching T.V. The care plan did not include interventions to prevent the development of pressure ulcers. Review of the Task List Report revealed the task for off-loading of extremities was not initiated until 12/10/2025 and the wound was identified on 08/18/25 as a SDTI. During an interview on 1/6/2026 at 2:45 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that preventative measures were not implemented until 12/10/25. The DON stated her expectation was that preventative measures be implemented prior to the development of pressure ulcers. Record review of the admission Record revealed Resident #4 was admitted to the facility on [DATE] with medical diagnoses that included Other Lack of Coordination, Type 2 Diabetes Mellitus with Hyperglycemia, and Peripheral Vascular Disease, Unspecified. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2025 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 01, indicating the resident had severely impaired cognition. Resident #58 Record Review of the Wound-Weekly Observation Tool, dated 9/15/25, revealed Resident #58 developed a Stage II pressure ulcer on sacrum, it is noted to have been identified on 9/13/2025. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Record Review of orders to treat were received on 9/15/2025. Registered Nurse (RN) #1 received the physician orders and performed wound care. During an interview on 1/7/2026 at 3:00 PM with RN #1, she stated she was unaware of wound until 9/15/25. This resulted in a two-day delay in physician notification, obtaining treatment orders, and initiation of wound care for Resident #58's Stage II pressure ulcer. During an interview on 1/7/2026 at 4:10 PM, the DON and ADON confirmed that the wound should have been reported, orders obtained and treated the same day the wound was identified and there should not be a delay in treatment. Record review of the admission Record revealed Resident #58 was admitted to the facility on [DATE] with medical diagnoses that included Giardiasis. Record review of the quarterly MDS with an ARD of 9/11/2025 revealed under Section C a BIMS score of 14, indicating no cognitive impairment.