

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 22CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/17/2024
NAME OF PROVIDER OR SUPPLIER GRENADA REHABILITATION AND HEALTHCARE CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1966 HILL DRIVE GRENADA, MS 38901		
(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #24201 and CI MS# 24338) at the facility from 4/16/24 through 4/17/24. During the survey, the SA determined the facility was in compliance with the with the Minimum Standards of Operation for Institutions of Aged or Infirm . The SA investigated pressure sores, activities of daily living, neglect, call lights, dress, weight loss, contractures, visitation, and environment, with no deficiencies cited. The facility held a license for 140 beds, with a census of 85.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/24/24