STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification and two (2) complaint investigations (CI MS #25383 and CI MS #25658) survey at the facility from July 15, 2024 to July 18, 2024. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies F609, F636, F638, F726, F851 and F880. CI MS #25383 and CI MS #25658 were investigated. No deficiencies were cited related to these complaints. The census at the time of survey was 90 and the facility is licensed for 105 beds.	F 000		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		8/22/24

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

Electronically Signed | 08/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 636	Continued From page 1 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 636	Continued From page 2 Based on record review, staff interview, and facility policy review, the facility failed to complete an Annual Minimum Data Set (MDS) no later than 14 days of the Assessment Reference Date (ARD) for one (1) of 19 assessments reviewed. Resident # 24 Findings include Record review of the facility policy CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) ... Chapter 5: Submission and Correction of the MDS Assessment," dated October 2023, revealed " ...5.2 Completion Timing: For all non-Admission OBRA (Omnibus Budget Reconciliation ACT) and PPS (Prospective Payment System) discharge assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference date (ARD) (A2300)..." Review of the Centers for Medicare & Medicaid Services (CMS) Submission Final Validation Report revealed Resident #24 's Annual assessment was completed more than 14 days after the assessment reference date. Record review of the annual Minimum Data Set for Resident #24 revealed in Section A2300- the Assessment Reference Date was documented as 6/06/2024. Section Z0500-Assessment Completion was documented as 7/01/24. In an interview with the MDS Coordinator on 7/17/24 at 10:53 AM, she confirmed after review of the CMS submission final validation report, Resident #24 's MDS was completed late. She revealed she was aware that the facility has previously had late assessments and revealed	F 636	1.On 07/25/2024 in-service was conducted with Minimum Data Set (MDS) nurse by Regional Case Mix Registered Nurse regarding (RAI) manual and requirements of the facility to perform annual MDS assessments. The Regional Case Mix will provide a report to the Administrator, the Director of Nurses, and the Regional Corporate Clinical Specialist of late transmissions from 6/1/2024 thru 8/16/2024. 2.Residents who reside in the facility for a year may be affected. 3.On 8/1/2024 an audit was conducted by MDS Registered Nurse Coordinator to determine how many annual MDS assessments needed to be submitted to attain compliance which reveal 3 annual assessments are needed for compliance; these assessments were completed on 8/5/2024. 4. Effective 7/26/2024 the Minimum Data Set (MDS) nurses will email a daily report of all MDS assessments that were completed that day. Effective 8/19/2024, the MDS nurses will give a report in the morning meeting, of any transmissions from the prior day that flagged "late transmissions" on the validation report. A report of all assessments for the month of July will be submitted to Quality Assurance Performance Improvement Committee on 8/20/2022 and then monthly thereafter by the MDS Coordinator for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 636	Continued From page 3 the MDS department has been placed on an action plan for about a year to address the problems, but confirmed the problems still exist. She stated she felt time management was part of the reason the assessments were late. In a phone interview with the MDS Consultant on 7/17/24 at 11:08 AM, she confirmed she was aware the facility was having issues with the MDS's being completed and submitted. She stated the facility had put a plan of action in place a few months ago to stop the late completion of the assessments, but confirmed the plan needed to be altered. She revealed the purpose of completing and transmitting the MDS timely is to ensure billing is correct and ensure the correct resident information is submitted to complete the residents' plan of care. Record review of the "Admission Record" revealed the facility admitted Resident #24 to the facility on 9/27/22 with current diagnoses that included Transient Cerebral Ischemic Attack.	F 636		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete a Quarterly Minimum Data Set (MDS) no later than 14 days of the Assessment Reference Date (ARD) for one (1) of 19 assessments reviewed.	F 638	1.On 07/25/2024 in-service was conducted with Minimum Data Set (MDS) nurse by Regional Case Mix Registered Nurse regarding (RAI) manual and requirements of the facility to perform	8/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 638	Continued From page 4 Resident # 49 Findings include Record review of the facility policy CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) ... Chapter 5: Submission and Correction of the MDS Assessment," dated October 2023, revealed " ...5.2 Completion Timing: For all non-Admission OBRA (Omnibus Budget Reconciliation ACT) and PPS (Prospective Payment System) discharge assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference date (ARD) (A2300) ..." Review of the CMS Submission Final Validation Report revealed Resident #49 ' s Quarterly assessment was completed more than 14 days after the assessment reference date. Record review of the quarterly Minimum Data Set for Resident #49 revealed in Section A2300- the Assessment Reference Date was documented as 6/07/2024. Section Z0500-Assessment Completion was documented as 7/03/24. During an interview with the MDS Coordinator on 7/17/24 at 10:53 AM, she confirmed after review of the CMS submission final validation report that Resident #49's MDS was completed late. She revealed she was aware that the facility has previously had late assessments and the MDS department has been placed on an action plan for about a year to address the problems, but confirmed the problems still exist. She stated she felt time management was part of the reason for the assessments were late.	F 638	quarterly MDS assessments. The Regional Case Mix will provide a report to the Administrator, the Director of Nurses, and the Regional Corporate Clinical Specialist of late transmissions from 6/1/2024 thru 8/16/2024. 2.Residents who reside in the facility for three months may be affected. 3.On 8/1/2024 an audit was conducted by MDS Registered Nurse Coordinator to determine how many quarterly MDS assessments needed to be submitted to attain compliance which reveal 10 quarterly assessments are needed for compliance; these assessments were completed on 8/5/2024. 4. Effective 7/26/2024 the Minimum Data Set (MDS) nurses will email a daily report to the Administrator, Director of Nurses, and the Corporate Clinical Specialist of all MDS assessments that were completed that day. Effective 8/19/2024, the MDS nurses will give a report in the morning meeting, of any transmissions from the prior day that flagged "late transmissions" on the validation report. A report of all assessments for the month of July will be submitted to Quality Assurance Performance Improvement Committee on 8/20/2022 and then monthly thereafter by the MDS Coordinator for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 638	Continued From page 5 During a phone interview with the MDS Consultant on 7/17/24 at 11:08 AM, she confirmed she was aware the facility was having issues with the MDS's being completed and submitted. She stated the facility had put a plan of action in place a few months ago to stop the late completion of the assessments, but confirmed the plan needed to be altered. She revealed the purpose of completing and transmitting the MDS timely is to ensure billing is correct, and the correct resident information is submitted to complete the resident's plan of care. Record review of the "Admission Record" revealed the facility admitted Resident #49 to the facility on 11/19/2019 with diagnoses that included Cerebral Palsy.	F 638		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		8/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 726	Continued From page 6 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure staff completed competency skills check-off and completed Enhanced Barrier Precautions training prior to caring for residents with a tracheostomy for one (1) of four (4) respiratory staff personnel files reviewed. Respiratory Therapist (RT) #1 Findings include: Record review of a type statement on facility letterhead dated 7/19/24 and signed by the facility Administrator revealed "(Facility proper name) does not have a policy for competency skills checkoffs." While observing tracheostomy care for Resident #53 on 7/17/24 at 10:00 AM, revealed an Enhanced Barrier Precaution sign on the resident's outer door. RT #1 performed tracheostomy care without proper Personal Protective Equipment, which included a gown. In an interview on 7/17/24 at 10:35 AM, RT #1 revealed that she wasn't sure if Resident #53 was	F 726	1.Respiratory Therapist #1 was in-serviced by the Director of Respiratory on 7/19/2024. On 7/18/2024 Resident #53 was assessed by the Director of Nurses (DON). No signs nor symptoms of distress nor worsening were noted. 2.All residents receiving tracheostomy care could have been affected; at that time, there were four residents with tracheostomies. 3.The Respiratory Therapy Director will conduct an In- service training on trach care for all Respiratory Therapists and Nurses starting 7/19/2024 with an end date of 8/2/2024. 4.Beginning 7/19/2024 competency checkoffs for all Respiratory Therapist and Nurses are being performed by the Director of Respiratory Therapy also weekly observations of trach care for 4 weeks, then monthly for 4 months by the Respiratory Therapy Director. All new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 726	Continued From page 7 under the enhanced barrier precautions or not and stated, "No, I don't think he is he doesn't have an infection." RT #1 glanced at the resident's door and then stated, "Oh yes, he has one of those signs on the door, I was supposed to wear a gown into his room." RT #1 revealed that she had not been trained in enhanced barrier precautions. In an interview on 7/17/24 at 10:50 AM, the Director of Nurses (DON) revealed all nursing staff were to be trained on enhanced barrier precautions and she was not aware that RT #1 was not trained. In an interview on 7/17/24 at 1:40 PM, the Assistant Director of Nurses (ADON) revealed she is the backup Infection Preventionist and confirmed that RT #1 had not been in-serviced on enhanced barrier precautions and confirmed that all staff was to be in-serviced. She revealed it is the responsibility of the Infection Preventionist and Staff development nurse to provide in-service to all staff, and they failed to ensure the in-service was completed for RT #1. In an interview on 7/18/24 at 8:32 AM, the DON confirmed RT #1 had not been trained on Enhanced Barrier Precautions. She revealed they had training in September 2023, with the epidemiologist involved, and that RT #1 was not trained at that time either. In an interview on 7/18/24 at 9:00 AM, the Respiratory Therapist Director revealed he has only been in the role of Director for about a month. He revealed he was unaware that RT #1 was not adequately trained on enhanced barrier precautions.	F 726	hires will be in-serviced and trained in trach care upon hire by the Director of Respiratory. All new hires will have a competency checkoff on trach care and will be observed performed trach care by the Director of Respiratory. This will be brought to the next Quality Assurance Performance Improvement meeting held on 8/20/2024. Modifications may be made to this process as that time and will be discuss monthly at the meeting thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 726	Continued From page 8 During an interview on 7/18/24 at 9:56 AM, the DON revealed that RT #1 did not have a competency skill checkoff for tracheostomy care. She confirmed the RT had been employed part-time since 2022 and usually worked one day a week.	F 726		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether	F 851		8/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 851	Continued From page 9 the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to submit accurate data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Second quarter 2024. Findings include: Record review of "PBJ Staffing Data Report	F 851	1.On 7/17/2024, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed an audit of all direct care hours worked during the 2nd quarter. Any direct care hours worked by department Managers/Salaried Staff, that were not submitted correctly for Payroll Based Journal purposes, were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 851	Continued From page 10 CASPER Report 1705D FY (Fiscal Year) Quarter 2, 2024 (January 1-March 31)", revealed "Excessively Low Weekend Staffing-Triggered. Triggered=Submitted Weekend Staffing data is excessively low." During an interview on 07/16/24 at 9:30 AM, the Human Resources/Payroll Coordinator revealed the corporate office submits the payroll-based journal. The Human Resources/Payroll Coordinator stated, "If one of the administrative nurses works a weekend shift, they are supposed to submit a form to me so I can manually change their hours." An interview on 07/17/24 at 3:45 PM, the Director of Nurses (DON) revealed regarding the low weekend staffing for the second quarter, " I worked a lot of those weekends to cover shifts" and revealed she wasn't sure if she had submitted the forms like she was supposed to. An interview on 07/17/24 at 4:05 PM, the Corporate Consultant confirmed the hours worked by the DON and the treatment nurse were not captured correctly on the PBJ report and were done so in error. She revealed the shifts for the second quarter of 2024 were covered, however, the data was entered incorrectly and did not capture the direct care on the PBJ. An interview on 07/18/24 at 8:24 AM, the DON revealed they were adequately staffed for the second quarter weekends, however after auditing revealed there were inconsistencies in reporting to the PBJ.	F 851	immediately corrected in the facility□s payroll system. 2.The resident daily population was not affected by the practice of not correctly reporting and submitting Department Managers/Salaried Staff hours, worked in direct care, to Centers of Medicare and Medicaid. 3.On 08/1/2024 the Administrator educated the Human Resources Generalist(HR) on mandatory submission of staffing information based on payroll data and to check daily staffing sheet to ensure that employees clocked in and out appropriately. The Corporate Payroll Journal Coordinator will monitor the PBJ report effective immediately. 4.Starting 8/1/2024, all Salaried Staff must submit a payroll editing form to HR for any hours worked in direct patient care. Beginning 8/1/2024 the corporate Payroll Based Journal Coordinator will confirm receipt of direct care hours bi-weekly for two months and then quarterly for one year. HR will submit a report to the Quality Assurance Performance Committee for review and recommendations on 8/20/2024, and monthly thereafter for four months.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 880	Continued From page 11 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 880	Continued From page 12 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection, as evidenced by failing to ensure Enhanced Barrier Precautions (EBP) and proper hand hygiene during resident care treatment for one (1) of four (4) resident care treatments observed. Resident #53 Findings include:	F 880	1.On 7/18/2024, Respiratory Therapist #1 was in-service on Enhanced Barrier Precautions by the Assistant Director or Nursing (ADON). 2.Thirty□five residents could have been affected. 3.Hand hygiene check off on all clinical staff starting 7/27/2024 with on ending date of 8/16/2024 by the Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 880	Continued From page 13 Record review of the facility policy titled, "Enhanced Barrier Precautions" dated 4/1/2024 revealed " ...Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove used during high contact resident care activities." Record review of the facility policy titled, "Handwashing/Hand Hygiene" with a revision date of 3/1/2020 revealed, "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections..." Record review of the facility policy titled, "Tracheostomy Care" with a revision date of March 2024 revealed " ...General Guidelines ... 3. Disposable gown must be worn as part of Enhanced Barrier Precautions...Preparation and Assessment ... 9. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle. 10. Wash hands. ... Clean the Removable Inner Cannula. ...8. Put on sterile gloves...14. Remove and discard gloves into appropriate receptacle...15. Wash hands and put on fresh gloves. Observation of tracheostomy (trach) care for Resident #53 on 7/17/24 at 10:00 AM, revealed an Enhanced Barrier Precaution sign on the resident's outer door. Respiratory Therapist (RT) #1 washed her hands briefly with an antiseptic hand sanitizer, applied gloves, and entered the	F 880	Development Nurse and the Infection Prevention Nurse. Nursing staff will be in-serviced on Enhanced Barrier Precautions by the Staff Development Nurse(SDN) and the Infection Control/Prevention (ICP) Nurse starting 7/27/2024. 4.Observation of staff donning Enhanced Barrier Precaution Personal Protective Equipment(PPE) prior to care; four times a week for 4 weeks and weekly for 4 weeks by the Director of Nursing(DON). This will be taken to Quality Assurance Program meeting on 8/20/2024 and monthly thereafter until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 880	Continued From page 14	F 880		

resident's room without applying a protective gown. The RT cleaned the overbed table and set up her barrier, discarded her gloves, and applied new gloves without washing her hands. She then proceeded to perform tracheostomy care. The RT removed sterile gloves from the suction catheter kit and applied the sterile gloves over her soiled gloves. The RT suctioned the resident and then removed her sterile gloves leaving her soiled gloves intact, failing to wash her hands. The RT opened the tracheostomy care tray with the soiled gloves, removed the sterile gloves, placed them over the non-sterile gloves, and continued tracheostomy care. The RT removed her gloves, packaged up the unclean trach supplies, and placed them in a red biohazard bag, she removed a soiled washcloth that was saturated with fluids that had been placed under Resident #53's trach for any excessive secretions and stated "I'm not supposed to put this on the floor, but I don't have anywhere to place it. There should be a container in here. RT #1 then placed the soiled washcloth on the floor and exited the room. She tucked the red biohazard bag under her arm and briskly applied antiseptic hand sanitizer from a bottle on the top of her treatment cart.

In an interview on 7/17/24 at 10:35 AM, Respiratory Therapist #1 revealed that she wasn't sure if Resident #53 was under enhanced barrier precautions or not and then stated, "No, I don't think he is he doesn't have an infection." The RT glanced at the resident's door and then stated, "Oh yes, he has one of those signs on the door, I was supposed to wear a gown into his room." She confirmed she had not worn the proper personal protective equipment into the room to render care to the resident. She revealed that she had not been trained in enhanced barrier

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 880	Continued From page 15	F 880		

precautions. RT #1 revealed that during her tracheostomy care, she was taught in school to keep her gloves on and put the sterile gloves over top of them and wasn't aware that she had to remove the soiled gloves and wash her hands during the dirty and clean process of rendering tracheostomy care. The RT revealed that she understood where it could be an infection control issue and confirmed that she had not used proper hand hygiene while performing tracheostomy care on Resident #53, and by not doing so, it's possible the resident could get an infection.

An interview on 7/17/24 at 10:50 AM, the Director of Nurses (DON) confirmed that the respiratory therapist was supposed to wear a gown into the room as part of the enhanced barrier precautions and to change out her gloves and wash her hands between the dirty and clean trach care and revealed "that is our standards of practice for tracheostomy care." The DON confirmed the resident could get an infection from the lack of proper hand hygiene and lack of proper personal protective equipment (PPE) during his tracheostomy care.

In an interview on 7/18/24 at 9:00 AM, the Respiratory Director confirmed that the standard of tracheostomy care to possibly prevent infections is to wear a gown and perform appropriate hand hygiene.

A record review of Resident #53's Admission Record revealed the resident was admitted to the facility on 05/29/2024 with diagnoses that included Pneumonitis due to inhalation of food and vomit, Cerebral infarction, and Encounter for attention to tracheostomy.