STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255156	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	**1966 HILL DRIVE , GRENADA, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted four (4) complaint investigations (CI) MS# 2623645, CI MS# 2626262, CI MS# 2639198 and CI MS# 2628498 at the facility on 10/28/25-10/29/25. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid for CI MS# 2623645, CI MS# 2626262, CI MS# 2639198 and CI MS# 2628498 and cited F 725. The SA also found the facility was not in compliance with CI MS# 2639198 and cited F 600 for abuse. The census at the time of the survey was 101 and the facility is licensed for 137 beds.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical abuse by a Certified Nurse Assistant (CNA) for one (1) of three (3) residents reviewed for abuse (Resident #7). This deficient practice resulted in the resident being forcefully pushed down onto the bed by a staff	F0600		

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 reverse for further 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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F0600 SS = G	Continued from page 1 member, creating potential for physical injury and psychological harm. Findings include: Review of the facility policy titled “Abuse Prohibition Policy,” last reviewed 5/17/25, revealed the following: Intent: Each resident has the right to be free from abuse...Definitions: Physical Abuse includes hitting, slapping, kicking, shoving, pinching, and controlling behavior through corporal punishment..." The policy further directed that all staff are responsible for immediately reporting any witnessed or suspected abuse and that any employee accused of abuse will be removed from resident care duties pending investigation. During an interview with the Administrator (ADM) on 10/28/25 at 2:55 PM, related to the facility-reported allegation of physical abuse involving Resident #7 and CNA #4, she confirmed that the facility did substantiate abuse occurred. She stated that CNA #1 came to her office that morning and reported witnessing CNA #4 abuse Resident #7. CNA #1 stated that she had asked for help to get Resident #7 dressed and that he was standing up beside his bed when CNA #4 had entered the room and pushed Resident #7 so hard that he fell on the bed. The ADM stated she immediately began an internal investigation, interviewed all parties involved, and assessed the resident. She stated the resident confirmed that CNA #4 had pushed him down from a standing position. The ADM reported that CNA #4 was immediately placed on administrative leave pending investigation and was terminated on 10/10/25 after the facility substantiated that the abuse did occur. An interview with Resident #7 on 10/28/25 at 2:50 PM revealed the resident was alert and oriented. When asked if he was okay, the resident stated, “I’m fine.” When asked specifically about CNA #4 pushing him onto the bed, the resident turned his head away and made no further comments and did not want to discuss it any further and appeared to withdraw from the conversation. Record review of the facility investigation dated 10/09/25 revealed that an interview was conducted with Resident #7 at the time of the incident and he confirmed that CNA #4 had pushed him down and stated, "Nothing will be done to her." Peer reviews were conducted with seven employees and two of the employees revealed that they had heard CNA #4 talk rough to residents in the facility. During an interview with CNA #1 on 10/28/25 at 1:00 PM, she stated that on 10/9/25 she had been reassigned to A	F0600		

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F0600 SS = G	Continued from page 2 Wing for the day and was unfamiliar with that hall. She stated she observed Resident #7 standing in his room with his brief off and refusing assistance from staff. CNA #1 stated she asked CNA #4 to assist her with the resident because she was unfamiliar with him. She stated CNA #4 then entered the room and said in a rough voice, “I can’t do what I want to because B Wing is over here.” CNA #1 stated that Resident #7 balled his fists but did not attempt to strike CNA #4 at all. She stated CNA #4 then “pushed the resident very hard,” causing him to fall backward onto the bed from a standing position. CNA #1 stated she immediately reported what she witnessed to the nurse and the administrator. During a phone interview with CNA #4 on 10/29/25 at 8:30 AM, she denied pushing Resident #7 down onto the bed. She stated she assisted the resident because he refused care from CNA #1. She stated she had cared for the resident frequently and that he was familiar with her. She confirmed she helped dress the resident and returned him to his chair but maintained that she did not abuse or push the resident. An interview with the Director of Nursing (DON) on 10/29/25 at 10:00 AM, she stated that staff abuse towards a resident could lead to physical harm, make them afraid and affect them mentally. Record review of an Abuse In-Service Attendance Sheet revealed CNA #4 last received abuse-prevention education on 6/10/25. The training included a review of abuse definitions, mandatory reporting, and staff responsibilities to treat all residents with dignity and respect. Record review of CNA #4’s time sheet revealed her last day worked was 10/9/25, with documentation confirming she was removed from duty at 10:05 AM pending investigation. Record review of a Personnel Action Form revealed CNA #4 was terminated on 10/10/25. Record review of the “Admission Record” revealed the facility admitted Resident #7 on 8/20/18 with a diagnosis that included cerebral infarction. Record review of Resident #7’s Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	F0600		
F0725 SS = F	Sufficient Nursing Staff	F0725		

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F0725 SS = F	Continued from page 3 CFR(s): 483.35(a)(1)(2) §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 §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to ensure sufficient qualified nursing staff were available at all times to provide nursing and related services to meet the residents' needs. This deficient practice resulted in prolonged call-light response times and delays in assistance with care needs and had the potential to affect all 101 residents residing in the facility. Findings include: Review of the facility policy titled “Staffing, Sufficient and Competent Nursing,” last reviewed 3/2023, revealed, “Policy Statement: Our facility provides sufficient numbers of nursing staff with the appropriate skills necessary to provide nursing and	F0725		

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F0725 SS = F	Continued from page 4 related care and services for all residents in accordance with resident care plans and facility assessment..." Resident #1 During an interview with Resident #1 during an onsite complaint investigation on 10/28/25 at 10:00 AM, she stated she has to wait too long to go to the bathroom. She stated she is often wet because she has an overactive bladder and cannot hold her urine that long. She stated, "I feel like the staff try, but they are stretched so thin with not enough people working. I can put my call light on, and it will be an hour before anyone comes, and even worse on the weekends. It happens too often." Record review of the Admission Record revealed Resident #1 was admitted on 8/19/25 with a diagnosis of overactive bladder. Record review of the Brief Interview for Mental Status (BIMS) dated 9/6/25 revealed a score of 15, indicating the resident was cognitively intact. Resident #2 An interview in the room with Resident #2's sitter on 10/28/25 at 9:50 AM revealed she was not trained to provide care, that the family had hired her to help because the resident has a trach and requires extensive help and assistance and to be at the facility to help the staff when he needs to be turned or to notify the staff when he needs help because he can't push the call light. She stated, "Sometimes we wait an hour or more for someone to come. He requires two staff for turning and incontinence care, and they have to wait until they can find someone to help." She stated, "The staffing is horrible." An interview with the Respiratory Therapist on 10/28/25 at 12:20 PM revealed, "It does take a while sometimes for the CNAs to change Resident #2 and he always requires two people because of the trach. Sometimes they have extra residents to care for because someone called in, and "we are short-staffed all the time." An interview with Resident #2's representative on 10/28/25 at 3:00 PM revealed she hired private sitters to ensure the staff were taking care of her husband. She stated, "You can call and wait hours before they come because he requires two people to care for him. There have been numerous times I call for help and just have to wait and wait." She stated a charge nurse told	F0725		

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F0725 SS = F	Continued from page 5 her, “We don’t have enough staff.” She stated my husband has only been here a few months, but I saw right away that when I wasn't here who would check on him because the staffing is so bad, so I hired sitters and it is costing me so much money, but I feel I don't have a choice right now. Record review of the Admission Record revealed Resident #2 was admitted on 9/12/25 with a diagnosis of anoxic brain damage. An interview with Certified Nurse Assistant (CNA) #2 on 10/28/25 at 1:30 PM revealed, “Staffing is terrible. The call-ins are out of control. Sometimes we have 15 to 16 residents per CNA. Yes, call lights go off longer, and residents don’t get changed as timely as they should. The workload is too much for the acuity of these bed-bound, total-care residents who often require the assistance of two staff.” An interview with Licensed Practical Nurse (LPN) #1 on 10/28/25 at 1:45 PM revealed, “We are short-staffed a lot. There are always call-ins, and that causes delays in care, especially if residents require more than one person to assist. The facility has a lot of total-care residents.” An interview with CNA #4 on 10/29/25 at 1:55 PM revealed, “The weekends is the worst. We have heavy loads and do the best we can to take care of the residents, but it does cause them to have to wait longer for care. We have high-acuity residents like those with tracheostomies and bed-bound residents requiring two staff.” An interview with the Ombudsman on 10/28/25 at 2:10 PM revealed she had spoken to the Administrator multiple times about the timeliness of care and answering call lights. She stated there had been multiple family and resident complaints, including from Resident #1 and Resident #2’s families. She stated, “I have advised the Administrator that I was receiving the same complaints repeatedly and that something had to be done. This has been going on for over three months.” She stated she informed the Administrator she would have to report the concerns if they were not corrected. An interview with the Administrator on 10/28/25 at 3:00 PM confirmed the facility had received numerous complaints from families and residents regarding staffing, delayed response to call lights, and timeliness of care. She stated, “Administration comes in to help, but call-ins are excessive and staff are leaving.” She stated she had reached out to Corporate	F0725		

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F0725 SS = F	Continued from page 6 about halting admissions, but that had not occurred. She confirmed there was a definite staffing concern at the facility and that residents are left waiting for help. During an interview with the Assistant Director of Nursing (ADON) on 10/29/25 at 9:55 AM, she stated she has been handling the schedule because there is no staffing coordinator at this time. She confirmed staffing is a major problem and stated, “Call-ins are excessive. Administration tries to cover the shift when someone calls in but there are often just more call-ins, and it is impossible to manage the residents care properly when there is just not enough help. We have lost staff due to changes being made to the schedule.” An interview with the Director of Nursing (DON) on 10/29/25 at 10:00 AM revealed there was a concern with staffing. She stated Administration staff help when they can, but there are numerous call-ins and that it can’t all be covered to meet the residents needs who require help. She stated they have changed the schedule, and some staff were unhappy and resigned. She confirmed there had been many complaints about staffing and lack of care. She stated her concern about not having enough staff is that it causes delays in care and answering call lights, which could lead to increased falls, accidents and residents left incontinent or needing help with meals. Record review of the staffing grid dated 10/29/25 revealed that on 10/26/25 the facility had four CNAs on the 3PM-11PM shift and the 11PM-7AM shift for 95 residents. On 09/14/25 the facility had four CNAs on the 3PM-11PM shift to care for 91 residents and on 09/20/25 on the 11PM-7AM shift the facility had three CNAs in the building to care for 89 residents. Record review of the facility roster matrix revealed that the facility had four wings in the building: A wing with 30 residents, B wing with 31 residents, C wing with 20 residents and a Tracheostomy unit with 13 residents for a total of 94 residents in the building when the complaints related to staffing were submitted to the state agency.	F0725		