Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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**

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M0000	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 the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm for CI MS# 2623645, CI MS# 2626262, CI MS# 2639198 and CI MS# 2628498 and cited M 225. The SA also investigated a facility reported incident (Incident #2639198) and found the facility was not in compliance and cited M 500 for resident rights. The census at the time of the survey was 101 and the facility is licensed for 137 beds.	M0000		
M0225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time	M0225		

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

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M0225	Continued from page 1 (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on resident, family, Ombudsman, and staff interviews, record review, facility staffing documentation, and policy review, the facility failed to ensure adequate numbers of competent nursing staff were available to meet residents' needs for timely and appropriate care. This deficient practice resulted in prolonged call-light response times and delays in assistance with care needs. Review of staffing documentation revealed that on 10/26/25 the facility was staffed below the state minimum requirement of 2.8 nursing hours per patient day (PPD), providing only 2.41 PPD. This deficient practice had the potential to affect all 101 residents residing in the facility.	M0225		

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M0225	Continued from page 2 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 related care and services for all residents in accordance with resident care plans and facility assessment...” Review of the facility staffing grid provided by the Assistant Director of Nursing (ADON) revealed that on 10/26/25, the total nursing hours were calculated at 2.41 per patient day (PPD), which is below the state minimum requirement of 2.8 PPD. This confirmed that staffing levels were insufficient to meet resident needs and supported interview findings of delayed care and prolonged call-light response times throughout the 100-bed facility. 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	M0225		

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M0225	Continued from page 3 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 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	M0225		

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M0225	Continued from page 4 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 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.	M0225		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:	M0500		

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M0500	Continued from page 5 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and	M0500		

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M0500	Continued from page 6 to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M0500		

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M0500	Continued from page 7 record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III 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 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	M0500		

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M0500	Continued from page 8 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 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,”	M0500		

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M0500	Continued from page 9 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.	M0500		