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 **04/06/2026**

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 three (3) Complaint Investigations (CI MS #2962512, CI MS #2969216, and CI MS #2969871) at the facility on 04/06/26. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. The SA identified non-compliance and cited M500 and M610 for CI MS #2962512 for failure to provide timely Activities of Living (ADL) care. There were no deficiencies cited for CI MS #2969216 and CI MS #2969871 related to verbal abuse. The census at the time of the survey was 99 with bed capacity of 136 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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	M0500		

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 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 observation, resident, resident representative, and staff interviews, and record reviews, the facility failed to ensure a resident's right to be treated with dignity and respect as evidenced by failure to respond in a timely manner to the resident's requests for assistance causing the resident embarrassment and humiliation for one (1) of four (4) residents reviewed, Resident #2. Findings include: On 04/06/26 at 11:00 AM an observation and interview with Resident #2 revealed him lying in bed and there were multiple large smears of a yellowish substance on his bed pad, fitted sheet and on his flat sheet. Resident #2 attempted to cover up the yellowish substance with the clean part of the top flat sheet. Resident #2 revealed that he had had a bowel movement, had been lying in a dirty diaper for over an hour and was waiting for someone to come in and change him. Resident #2 stated, “It’s hard to get anyone to come in here and clean me up, they don't care." Resident pressed his call light at 11:08 AM. On 04/06/26 at 12:23 PM an observation and interview with Resident #2 revealed him in the same position, lying in a soiled brief with yellow fecal matter smeared on his bed pad, fitted and flat sheets. He stated, “This makes me feel bad" and "No one else would want to lay here like this either.” He revealed that it was embarrassing and he was upset and he wanted to get out of there as soon as he could. Resident #2 confirmed that someone had come in earlier to see what he needed, went back out to get someone to help, and had not returned. On 04/06/26 at 12:30 PM during an observation and interview with Resident #2’s Resident Representative (RR), she asked how long her brother had to wait before	M0500		

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M0500	Continued from page 4 someone cleaned him up and changed him. She revealed that she had been there since 12:00 PM, had gone into his room and “found him in a mess” and he told her that he was waiting on someone to come in and change him. RR revealed that he had had a large bowel movement and it was all over him and his bed. She also revealed that when Resident #2 saw her enter his room, he was embarrassed and tried to cover it up with the clean part of his sheet. She revealed that she walked up to the nursing desk, told them he needed help and still no one came and she stated, “Nobody should be treated like this.” The RR revealed that she saw a nurse go into his room earlier and she came back out into the hall and text someone with her phone. She revealed that he’s been at the facility for 6-7 days after being in the hospital for over a month, he had to have one of his legs amputated, and he depended on the staff there to take care of him. On 04/06/26 at 12:46 PM during an observation and interview with the Administrator (ADM) and the Director of Nursing (DON) in Resident #2’s room, they confirmed that he was lying in a soiled brief and confirmed the yellow fecal matter smeared on the outside of his bed pad and both sheets. The Director of Nursing stated that Resident #2 could not do for himself and depended on staff to meet his needs and this was not acceptable. The DON revealed that leaving a resident in a soiled brief could result in skin breakdown, pressure ulcers and could be a dignity issue. The Administrator revealed that they expected their staff to answer call lights promptly and provide the care needed and not allow residents to be in this condition. The DON revealed that these residents were everyone’s responsibility and it takes teamwork to get the job done. The ADM revealed that no one would want to sit in a soiled brief and that Resident #2 should not have had to sit there embarrassed, having to wait that long to be changed. Record review of Resident #2's "Admission Record" revealed an admission date of 03/25/26 and that his diagnoses included Traumatic Subarachnoid Hemorrhage with Loss of Consciousness, Multiple Fractures of Ribs, Left Side. Record review of Resident #2's "Progress Note" dated 03/26/26 revealed "...Resident has a Right BKA (Below the Knee Amputation)...Dependent on staff for all needs at this time with ADLs, transfers, turning and repositioning..." Record review of Resident #2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/30/26 under	M0500		

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M0500	Continued from page 5 Section C revealed a Brief Interview for Mental Status (BIMS) Score of 13 which indicated that he was cognitively intact.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on observation, staff and resident interviews, record review, and facility policy review the facility failed to provide timely incontinence care for a resident, causing the resident embarrassment and humiliation. This also put the resident at risk for skin impairment and discomfort for one (1) of four (4) residents reviewed. Resident #2. Findings Include: Review of the facility policy "Activities of Daily Living (ADL), Supporting" with revision date of March 2018, revealed "...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene..." An observation and interview with Resident #2 on 04/06/26 at 11:00 AM revealed him lying in bed and there were multiple large smears of a yellowish substance on his bed pad, fitted sheet and on his flat sheet. Resident #2 attempted to cover up the yellowish substance with the clean part of the top flat sheet. Resident #2 revealed that he had had a bowel movement, had been lying in a dirty diaper for over an hour and was waiting for someone to come in and change him. Resident #2 stated, “It’s hard to get anyone to come in	M0610		

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M0610	Continued from page 6 here and clean me up, they don't care." Resident pressed his call light at 11:08 AM. An observation on 04/06/26 at 11:11 AM revealed an unidentified staff member enter Resident #2's room, she deactivated the call light and exited. An observation and interview on 04/06/26 at 12:23 PM with Resident #2 revealed him in the same position, lying in a soiled brief with yellow fecal matter smeared on his bed pad, fitted and flat sheets. He stated, “This makes me feel bad" and "No one else would want to lay here like this either.” He revealed that it was embarrassing and he was upset and he wanted to get out of there as soon as he could. Resident #2 confirmed that someone had come in earlier to see what he needed, went back out to get someone to help, and had not returned. An observation and interview on 04/06/26 at 12:30 PM with Resident #2’s Resident Representative (RR), revealed her sitting at the table in the dining room that was across the room from Resident #2’s room. Resident #2’s RR asked how long her brother had to wait before someone cleaned him up and changed him. She revealed that she had been there since 12:00 PM, had gone into his room and “found him in a mess” and he told her that he was waiting on someone to come in and change him. RR revealed that he had had a large bowel movement and it was all over him and his bed. She also revealed that when Resident #2 saw her enter his room, he was embarrassed and tried to cover it up with the clean part of his sheet. She revealed that she walked up to the nursing desk, told them he needed help and still no one came and she stated, “Nobody should be treated like this.” RR revealed that she saw a nurse go into his room earlier and she came back out into the hall and text someone with her phone. She revealed that he’s been at the facility for 6-7 days after being in the hospital for over a month, he had to have one of his legs amputated, and he depended on the staff there to take care of him. An observation and interview on 04/06/26 at 12:35 PM with Certified Nursing Assistant (CNA) #1, revealed her out in the hall taking a lunch tray to the cart. She revealed that Licensed Practical Nurse (LPN) #1, notified her about Resident #2 needing to be changed a while ago, and her next stop was to take care of him. She revealed that she was very busy, that she went out to get supplies to change him and saw that the lunch trays had been delivered to the floor. CNA #1 revealed that she went and passed out trays and had to feed another resident before her food got cold. She again	M0610		

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M0610	Continued from page 7 stated, “I was going to change Resident #2 as soon as I finished feeding the resident.” CNA #1 was tearful and confirmed that she would not want to be in a soiled brief for a long time and neither should he have to be. She also agreed that lying in a soiled brief for a long time could cause skin breakdown and that they were supposed to keep residents clean and dry. She agreed that she should have changed Resident #2 sooner and if she couldn’t get to him timely, she should have asked for help. An interview on 04/06/26 at 12:42 PM with LPN #1, revealed that Resident #2’s sister came to her and asked for someone to change him. She revealed that she went into the room and told Resident #2 that she was getting him some help, and then texted CNA #1, who said she was coming on in there to take care of him. LPN #1 confirmed that she had not followed up and did not know that CNA #1 had not changed him. She revealed that it was not acceptable to leave a resident in a soiled diaper or brief for long periods of time and confirmed that this could cause skin breakdown. She revealed that they were supposed to make rounds every two hours and if residents called to be changed, they were supposed to change them and not allow them to remain wet or soiled. During an observation and interview on 04/06/26 at 12:46 PM with the Administrator (ADM) and the Director of Nursing (DON) in Resident #2’s room, they confirmed that he was lying in a soiled brief and confirmed the yellow fecal matter smeared on the outside of his bed pad and both sheets. The Director of Nursing stated that Resident #2 could not do for himself and depended on staff to meet his needs and this was not acceptable. She revealed that after CNA #1 saw him in this shape, she should have immediately gone back in and cleaned him up and not put him off. The DON revealed that leaving a resident in a soiled brief could result in skin breakdown, pressure ulcers and could be a dignity issue. The Administrator revealed that they expected their staff to answer call lights promptly and provide the care needed and not allow residents to be in this condition. The DON further revealed that if CNA #1 was busy, she could and should have asked someone for help. The ADM revealed that CNA #1 should have asked someone to help pass the trays or assist in getting Resident #2 changed. She revealed that these residents were everyone’s responsibility and it takes teamwork to get the job done. ADM revealed that communication was the key and if she voiced that she needed help, someone would have helped. She revealed that no one would want to sit in a soiled brief and that Resident #2 should not have had to sit there embarrassed, having to wait	M0610		

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M0610	Continued from page 8 that long to be changed. An observation on 04/06/26 at 12:50 PM revealed that CNA #1 entered Resident #2's room with her supplies to provide care, an hour and fifty minutes later than the first observation. Record review of Resident #2's "Admission Record" revealed an admission date of 03/25/26 and that his diagnoses included Traumatic Subarachnoid Hemorrhage with Loss of Consciousness, Multiple Fractures of Ribs, Left Side. Record review of Resident #2's "Progress Note" dated 03/26/26 revealed "...Resident has a Right BKA (Below the Knee Amputation).....Dependent on staff for all needs at this time with ADLs, transfers, turning and repositioning....." Record review of Resident #2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/30/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 13 which indicated that he was cognitively intact.	M0610		