STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255104	A. BUILDING _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA LIVING CENTER	**1950 GRANDVIEW 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 complaint survey for MS #18378 and MS# 18502 at the facility from 04/05/2022 to 04/06/2022/2022 along with an Employee Vaccination section of the Infection Control survey. During the survey, the SA determined that the facility followed the requirements for participation in Medicare and Medicaid. The SA did not substantiate noncompliance with MS #18378 Quality of care /treatment Quality of care resident left soiled for extended period of time, Resident Dressed improperly and No pressure sore precaution taken by facility, MS # 18502 Quality of Care /Treatment: water not offered, resident not groomed adequately, Resident not assessed for change in medical condition timely, and client services not performed per plan of care and physician orders were not substantiated and there were no deficiencies cited. The Facility was licensed for 120 beds and the census was 73 at the time of the survey.	F 000		

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

Electronically Signed | 04/19/2022

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 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.