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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grenada Living Center	1950 Grandview Drive Grenada, MS 38901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47874 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure a call light was accessible for one (1) of 17 residents reviewed for call lights. Resident #45. Findings Include: Review of the facility policy titled Call Light/Bell with a revision date of 1/24 revealed under, Purpose: To provide the resident with a means of communication with staff members .To provide staff members with a means of summoning assistance when they are with the resident . An observation and interview with Resident #45 on 4/07/25 at 10:50 AM revealed he was sitting in his wheelchair inside his room watching television. The right side of the bed was turned against the wall with the call light cord wrapped around the bed rail multiple times, and the end of the call light was hanging down behind the bed, unreachable. The resident verbalized that he used the call light to request help but could not do that with it tied to the bed rail where he could not access it. He revealed that if he needed help, he would roll his wheelchair to the door and shout for help in the hallway. An observation of Resident #45 on 4/07/25 at 1:42 PM revealed him sitting in his wheelchair in his room. The call light continued to be wrapped around the right bed rail, which was up against the wall. An observation and interview with Certified Nurse Aide (CNA) #4 on 4/07/25 at 1:50 PM confirmed Resident #45's call light was inaccessible to him. She revealed the resident used the call light and explained that without it being accessible, he would not be able to call for help. An interview with Licensed Practical Nurse (LPN) #3 on 4/07/25 at 1:55 PM revealed the call light should always be in reach for Resident #45, so he could call staff if he needed something. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident # 45 was moderately cognitively impaired. Record review of the Admission Record revealed the facility admitted Resident #45 on 2/29/24 with a medical diagnosis of Epilepsy.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff and resident interview, record review, and facility policy review the facility failed to honor a resident's choice related to food preferences for one (1) of two (2) residents reviewed for choices. Resident #61. Findings Include: Record review of the facility policy Dignity and Respect with revision date of 07/22 revealed A facility must . care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility shall protect and promote the rights of the residents .3. All residents should have autonomy of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care .4 .Resident's individual preferences regarding such things as menus .will be elicited and respected by the facility, and efforts will be made to accommodate these wishes . An observation and interview on 4/07/25 at 12:10 PM with Resident #61 revealed she was sitting in her room eating her lunch meal. She stated that she did not like rice or greens, and they had those foods on her meal tray today. An observation of the resident's lunch tray confirmed she had rice and mustard greens along with red beans, cornbread, pork chop, yogurt and banana pudding. She admitted that she had told them months ago that she didn't eat rice and greens, but they continued to put them on her plate. She also revealed that greens and rice were listed on her meal ticket under dislikes. An observation of the resident's meal ticket confirmed that rice and greens were listed under dislikes. An interview on 4/08/25 at 11:45 AM with Registered Nurse (RN) #1 confirmed that there was a place on the meal ticket's that listed the resident's likes and dislikes, and the residents should not receive those foods. She revealed that staff assisted the residents to fill out their preferences and choices and that the Dietary Manager kept up with them. An interview on 4/08/25 at 1:04 PM with the Dietary Manager (DM) confirmed that Resident #61's Lunch Meal Ticket dated 4/07/25 had dislikes documented that included mustard greens and rice and that she should not have received those two food items. He confirmed that the lunch menu on 4/07/25 consisted of a pork chop, red beans and rice, greens, banana pudding, and cornbread. The Dietary Manager revealed that the kitchen staff were supposed to follow the meal tickets as the plates were being passed down the line and that the greens and rice must have been put on Resident #61's plate by mistake. He revealed that he evaluated residents when admitted , went over their likes, dislikes, and preferences and the dietary staff were supposed to prepare their meal trays accordingly. He confirmed that Resident #61's dislikes were not honored, and she should not have received the greens and rice. An interview on 4/09/25 at 12:50 PM with the Administrator confirmed that resident food likes, dislikes and preferences were assessed when admitted to the facility and that Resident #61 should not have been served foods that were on her dislike list, stating, That's on us. The Administrator also revealed that the dietary staff should be reading and following those meal tickets when serving meals and admitted that residents had the right to make food choices. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #61's Dietary Admission Interview Form with admitted [DATE] revealed that Rice, Mustard and Turnip Greens under Food Preferences were answered No. Record review of Resident #61's Dislike and Allergy Report revealed that she disliked Rice, Turnip Greens, and Mustard Greens. Record review of Resident #61's Lunch Meal Ticket dated 4/07/25 revealed that her dislikes included Mustard Greens and Rice. Record review of Resident #61's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Type 2 Diabetes Mellitus, Unspecified Anemia, and Unspecified Anxiety Disorder. Record review of Resident #61's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interview, record review, and facility policy review, the facility failed to accurately submit a resident's information for Preadmission Screening and Resident Review (PASRR) for a Level II evaluation for one (1) of three (3) residents reviewed for PASRR. (Resident #43) Findings include: Review of the facility policy titled, Pre-Admission Screening PAS/PASRR (MS Only) last reviewed 8/24, revealed, To enter a Long-Term Care program an eligible beneficiary must have a Pre-Admission Screening (PAS) application completed to determine clinical eligibility for individuals seeking admission to a Division of Medicaid certified nursing facility on all residents regardless of payor source . Process . Review the medical records and other relevant medical documentation to verify major medical conditions and services . Record review of the Admission Record revealed Resident #43 was admitted on [DATE], with diagnoses of Unspecified Psychosis, Major Depressive Disorder, and Psychotic Disorder with Delusions. Record review of Resident # 43's Active Orders as of 12/09/24 revealed, Citalopram hydrobromide 20 mg (milligram) one tablet by mouth one time a day related to Major Depressive disorder, Haloperidol 1 (one) mg tablet by mouth every 8 (eight) hours related to Unspecified Psychosis, and Trazodone 50 mg 1 (one) tablet orally at bedtime related to Psychotic disorder with delusions. Record review of Resident #43's intake information for PASRR dated 12/09/24 revealed, Section I: Medications: coded no medications specified .Section J: Disease Diagnoses: coded only the admitting diagnosis of Cerebral Infarction . Section L: Referral Questions: 31. Does Resident # 43 have any history of mental illness? answered No .32. Does Resident #43 take, or have a history of taking psychotropic medications? answered No. During an interview with the Accounts Manager on 4/8/25 at 10:30 AM, she revealed she completed the Pre-Admission Screening on admission for Resident #43. She confirmed that she did not list any diagnoses other than the admitting diagnosis of Cerebral Infarction. She stated she never adds any other diagnosis than the primary diagnosis. She also revealed that she was not familiar with all the psychiatric diagnoses or the psychotropic medications that may need to be included. She confirmed, after reviewing the active orders as of 12/09/24 (the day the PAS was completed), that the resident was admitted on psychotropic medications and had psychiatric diagnoses that should have been submitted to determine the need for a Level II PASRR referral. She acknowledged it was an oversight on her part. She then revealed a concern that incorrectly completing the PAS could result in a resident with psychiatric diagnoses not receiving the additional services they may need. An interview with the Director of Nursing on 4/9/25 at 10:40 AM revealed that she reviewed Resident #43's 12/9/24 PAS and confirmed that it was coded incorrectly. She confirmed that the resident was admitted with mental health diagnoses and on psychotropic medications. She stated that the purpose of the PAS is to identify the resident's needs to ensure the resident is appropriate for placement in the facility and to determine if the resident needs a referral for a Level II PASRR for any extra mental health services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Worker on 4/8/25 at 11:00 AM confirmed, after review of the PAS completed on admission for Resident #43, that it was not completed correctly. She stated the resident was admitted with psychiatric diagnoses and on psychotropic medications and should have been referred for a Level II PASRR. She revealed that the accuracy of the PASRR is important to ensure the resident is appropriate for the facility and that the facility can meet the resident's mental health needs and provide any additional services required. She then stated that incorrectly completing the PAS could result in a resident not receiving needed care and services. A record review of Resident #43's Admission Minimum Data Set (MDS) dated [DATE], revealed Section N: Medications coded as taking antipsychotic and antidepressant medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interviews, record review, and facility policy review, the facility failed to implement a care plan related to fluid restriction for one (1) of 17 resident care plans reviewed. (Resident #20). Findings include: Review of a facility policy titled, Care Plan Process, last revised 12/24, revealed, The comprehensive care plan is an interdisciplinary communication tool .The care plan must include measurable objectives and timeframes and must describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Review of a care plan for Resident # 20 revealed, Focus The resident is at risk for nutritional problems r/t (related to) ESRD (End Stage Renal Disease) with fluid restriction on Hemodialysis . last revised 9/05/24 Interventions: 1000 ml (milliliters) fluid restriction. Document fluid intake. Day shift not to exceed 450 ml. Evening shift not to exceed 450 ml. Night shift not to exceed 100 ml . Record review of the Intake and Output (I&O) forms for Resident #20 from 3/30/25 through 4/7/25 revealed incomplete documentation. Daily 24-hour totals ranged from 240 ml to 400 ml. The (I&O) records lacked documentation necessary to determine if the resident's prescribed fluid restriction was being maintained. An interview on 4/08/25 at 3:25 PM, the Director of Nursing (DON) confirmed that staff were not consistently following the resident's care plan as it related to fluid restriction and intake documentation. During an interview conducted on 4/09/25 at 9:10 AM, the Minimum Data Set (MDS) Nurse reviewed Resident #20's care plan and stated that if staff were not documenting the total daily fluid intake, then the care plan was not being implemented. She stated the care plan serves to direct resident-specific care and failure to implement it could result in the residents receiving more fluids than ordered. Record review of the Admission Record revealed that Resident #20 was admitted to the facility on [DATE] with diagnoses that included Hypertensive Heart and Kidney Disease with Heart Failure and Stage 5 Chronic Kidney Disease (End-Stage Renal Disease).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interviews, record review, and facility policy review, the facility failed to ensure accurate monitoring and documentation of fluid intake for a resident on fluid restriction for one (1) of (4) four residents reviewed for fluid restrictions (Resident #20). Findings include: Review of the facility policy titled, Fluid Restriction, last reviewed February 2022, revealed the policy statement: Fluids will be restricted for residents as directed by the physician orders . Procedure: 3. Nursing service will document intake . Record review of the Order Summary Report for Resident #20 revealed an order dated 8/26/24 for a 1000 milliliter (ml) fluid restriction. The order directed that fluid intake must be documented and specified the following shift limits: day shift not to exceed 450 ml, evening shift not to exceed 450 ml, and night shift not to exceed 100 ml. Record review of the Intake and Output (I&O) forms for Resident #20 from 3/30/25 through 4/7/25 revealed incomplete documentation. Daily 24-hour totals ranged from 240 ml to 400 ml. The (I&O) records lacked documentation necessary to determine if the resident's prescribed fluid restriction was being maintained. During an interview with Certified Nurse Assistant (CNA) #2 on 4/8/25 at 3:11 PM, she stated she was aware that Resident #20 was on a fluid restriction. CNA #2 further stated that CNAs are expected to report the amount of fluids the resident consumes during meals to the nurse. She confirmed that she had not been reporting the resident's fluid intake to the nurse. During an interview with Licensed Practical Nurse (LPN) #3 on 4/8/25 at 3:15 PM, she revealed she was assigned to Resident #20 on the day shift. LPN #3 stated she was aware the resident was receiving dialysis but was not aware the resident was on a fluid restriction. She also confirmed that the CNAs do not notify her of how much fluid the resident consumes during meals. During an interview with LPN #4 on 4/8/25 at 3:20 PM, she stated she provided care for Resident #20 during the evening shift. LPN #4 confirmed she was aware the resident was on a fluid restriction but was unsure of the prescribed fluid restriction amount. She also confirmed that the CNAs do not report the resident's fluid intake to her during the shift. She stated she only documented the fluids she directly gave to the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 4/8/25 at 3:25 PM, she confirmed that upon review of the I&O forms from 3/30/25 to 4/7/25, staff were not accurately documenting the total amounts of fluid consumed by Resident #20. She stated that CNAs are responsible for informing nurses of the amount of fluids the resident drinks during meals, and nurses are expected to ensure the intake is documented correctly and that the resident's prescribed fluid restriction is followed. She acknowledged that the current documentation was inaccurate and incomplete, and therefore staff had no way to accurately assess how much fluid the resident was consuming. The DON expressed that concerns from this deficient practice could result in the residents consuming too much or too little fluid, potentially leading to fluid overload or dehydration. Record review of the Admission Record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Hypertensive Heart and Kidney Disease with Heart Failure and Stage 5 Chronic KidneyDisease and End-Stage Renal Disease. Record review of Resident #20's Quarterly Minimum Data Set (MDS) dated [DATE], Section O, revealed the resident was receiving dialysis while in the facility.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 47874 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to follow a physician 's order for a referral to a pain management clinic for Resident #23, this was for one (1) of three (3) residents reviewed for pain. Findings Include: Review of the facility policy titled Pain Screen and Management with a revision date of 12/23 revealed, All residents who experience routine pain receive a comprehensive pain screening and a treatment plan until an acceptable level of relief of pain is achieved. All residents have the right to treatment for pain. On 4/07/25 at 11:15 AM, an observation and interview with Resident #23 revealed he was lying in bed and verbalized he was hurting in his lower abdomen (kidney area) and his lower ribs (lung area). The resident revealed he was unsure if he had taken something for the pain. An observation and interview of Resident #23 on 4/08/25 at 9:40 AM revealed he was lying in bed and the resident stated that he was hurting all over. The resident revealed that he had had a log truck accident in the past with injuries, including a skull fracture, a broken collarbone, and a broken hip, which required a hip replacement. He reported shoulder and hip pain radiating up his spine, described his pain as throbbing, and rated it 8 out of 10 on a pain scale. He added that he had just taken a bunch of pills and thought the nurse had given him something. During an interview with Licensed Practical Nurse (LPN) #3 on 4/08/25 at 9:50 AM, she confirmed that she gave the resident a PRN (as needed) a Methocarbamol (muscle relaxant) at 8:40 AM after he told her he was hurting in his shoulders and sides. She added the resident took Gabapentin scheduled three times a day for nerve pain and chronic pain and took Robaxin every 6 hours as needed for muscle spasm. According to LPN #3, the resident reported that Neurontin and the muscle relaxer provided relief. She stated that she knew the doctor had made a referral to the pain clinic several months ago, but she was unsure what happened, but he did not go. Record review of Resident #23's Order Details revealed a physician order dated 1/07/25, Refer resident to pain management due to left shoulder and left hip pain. Record review of Resident #23's Medication Administration Record (MAR) revealed, an order dated 7/01/24 Gabapentin (nerve pain/chronic pain) Oral Capsule 300 MG (milligrams) give 1 capsule by mouth three times a day related to pain. Also revealed and order dated 1/27/25, Methocarbamol (muscle relaxant) Oral Tablet 500 MG (milligram) give 1 tablet by mouth every 6 hours as needed for pain related to other muscle spasm. The MAR revealed the resident received Methocarbamol on the following dates and times: 4/01/24 at 6:00 AM 4/02/24 at 12:15 AM (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/03/25 at 12:23 AM and 9:22 AM 4/04/25 at 12:02 AM and 9:34 AM 4/05/25 at 12:18 AM, 9:16 AM, and 11:30 PM 4/07/25 at 6:04 AM and 11:31 PM 4/08/25 at 8:45 AM An interview with the Nurse Practitioner (NP) on 4/08/25 at 11:39 AM revealed Resident #23 has a history of mental illness and drug abuse. She explained that he has multiple allergies to pain medications and commented, Basically there's nothing we can give him. She revealed therapy and lidocaine patches had been tried previously, and x-rays and tests had not revealed any specific injury. The NP revealed the resident says the muscle relaxant was effective. She confirmed the resident's physician made a referral to pain management but was unsure why he never went. An interview with the Director of Nursing (DON) on 4/08/25 at 3:02 PM confirmed that Resident #23's pain management referral was never made and acknowledged that this could result in a delay in the residents receiving appropriate care and pain relief. An interview with the Medical Record's (MR) Nurse on 4/08/25 at 3:15 PM revealed Social Services would have been responsible for making Resident #23's pain appointment. However, the appointment was never scheduled, and the order was discontinued after 90 days. An interview with Social Services (SS) on 4/08/25 at 3:20 PM revealed that she never received a copy of Resident #23's physician's order and was therefore unaware of the pain management referral. During a telephone interview on 4/09/25 at 9:21 AM, with Resident #23's Medical Doctor (MD), he revealed the resident's pain had evolved over time. He described a complex history, including multiple geriatric psychiatry admissions and medication management regimen. He revealed the resident required high doses of medication to manage paranoia, which also lowered his blood pressure and had contributed to nighttime falls. The MD explained that the resident had end-stage chronic obstructive pulmonary disease (COPD) and a history of traumatic injuries. He stated that he believed the resident's pain was neuropathic and that Methocarbamol and Gabapentin may provide some relief with pain brought on by those type of injuries. He confirmed that he made a referral to pain management for the resident's shoulder and hip pain and felt the resident would still benefit from seeing a pain specialist. The MD also noted that during a recent visit on 4/07/25, the resident complained of abdominal pain caused by constipation related to immobility and was started on Simethicone for gas relief. He emphasized that the resident's pain should be addressed and acknowledged that his case was complex due to underlying mental illness and COPD. Record review of Resident #23's Progress Note dated 1/07/25 revealed under, Assessment and Plan: . Chronic pain syndrome-Continue Gabapentin (nerve pain) 300 mg (milligrams) TID (three times daily)-refer to pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MDS with an Assessment Reference Date (ARD) of 3/14/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #23 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #23 on 8/22/24 with a medical diagnosis that included Chronic Obstructive Pulmonary Disease and Pain, Unspecified.