| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255156 | A. Building<br>B. Wing | 10/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grenada Rehabilitation and Healthcare Center | 1966 Hill Drive<br>Grenada, MS 38901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>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:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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, 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Record review of a Personnel Action Form revealed CNA #4 was terminated on 10/10/25.<br><br>Record review of the admission Record revealed the facility admitted Resident #7 on 8/20/18 with a diagnosis that included cerebral infarction.<br><br>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. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 related care and services for all residents in accordance with resident care plans and facility assessment .Resident #1During 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 [DATE] 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 #2An 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 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 [DATE] 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 about halting admissions, but that had not occurred. She confirmed there was a definite staffing concern at the facility and |