STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grenada Rehabilitation and Healthcare Center	1966 Hill Drive 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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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 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 (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	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.

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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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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 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 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 (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	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 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.