

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 09/17/2026	
NAME OF PROVIDER OR SUPPLIER GRENADA REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1966 HILL DRIVE , GRENADA, Mississippi, 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	
M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with three (3) complaint investigations (CI MS # 3004335, CI MS #3146420, and CI MS #3167239) at the facility from 9/14/26-9/17/26. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M610 related to Activities of Daily Living for CI MS # 3004335 and CI MS #3167239. There were no deficiencies cited for CI MS #3146420. The SA also cited M500, M620, M625, M735, and M1570. The census at the time of the survey was 99 and the facility is licensed for 116 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 documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in		M0500				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0500	Continued from page 1 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 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;	M0500					

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M0500	Continued from page 2 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 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	M0500					

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M0500	Continued from page 3 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 II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents were afforded their resident rights, including the right to be treated with dignity and respect (Resident #36), to have grievances promptly addressed (Resident #46) and to have identified preferences and choices honored (Resident #62 and Resident #85) for four (4) of 26 sampled residents. Resident #36, Resident #46, Resident #62, and Resident #85 Findings Include: Dignity and Respect Resident #36 Review of facility policy titled "Nursing Facility Resident Rights," dated 3/6/2026, revealed, "...The following rights are guaranteed to residents...to be treated with dignity, courtesy, and respect...to receive care necessary to achieve the highest practicable physical, mental, and psychosocial well-being..." During an initial interview on 9/14/2026 at 12:56 PM, Resident #36 stated nurses and Certified Nursing Assistants (CNAs) had instructed her to urinate in her brief instead of providing a bedpan when she requested one. Resident #36's roommate was present during the interview and stated she personally heard staff instruct Resident #36 to urinate in her brief rather than provide the requested bedpan. During an interview on 9/15/2026 at 2:20 PM, the Director of Nursing (DON) stated that if a resident requested a bedpan, the resident should be provided with one. When questioned about staff instructing residents to "pee in their diaper," the DON stated, "No way should they ever be told that by the staff." Record review of a facility in-service document titled "Infection Control-Survey Readiness," dated 5/19/26, revealed, "Do not tell a resident to "just go in your diaper" when they ask to use the restroom. Assist them to the bathroom or offer bedpan/bedside commode."			M0500			

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M0500	Continued from page 4 During an interview on 9/16/2026 at 12:06 PM, the Certified Occupational Therapy Assistant (COTA) stated Resident #36 currently required a bedpan for toileting and would continue to require one for the foreseeable future. The COTA stated it would be unsafe for staff to transfer Resident #36 to the toilet but confirmed that use of a bedpan was safe for the resident. Record review of Resident #36's Admission Record revealed the resident was admitted to the facility on 8/12/26 with medical diagnoses that included Unspecified Severe Protein-Calorie Malnutrition, Adult Failure to Thrive, Foot Drop, Right Foot and Foot Drop, Left Foot. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/31/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 13 under Section C, which indicated Resident #36 was cognitively intact. Self-Determination Review of the facility policy titled "Nursing Facility Resident Rights," which was undated, revealed under "Quality of care and participation in care: To receive care necessary to achieve the highest practicable physical, mental, and psychosocial well-being." The policy also revealed under, "Freedom of choice and autonomy: To make choices about daily life, schedules, clothing, and activities... To participate in activities inside and outside the facility." Resident #62 An observation and interview with Resident #62 on 9/15/26 at 8:30 AM revealed she was lying in bed. She stated she loved attending activities, especially church services, but staff did not get her up because there were not enough staff available. Resident #62 stated she required a lift for transfers, which required two staff members. She stated church services were held on Wednesday mornings. Because staff had to get her up for dialysis, she had asked them to get her up earlier so she could attend church services, but they did not. Resident #62 stated church services were the most important activity she requested to attend. Further observation revealed the resident had difficulty locating the food items while attempting to eat breakfast from a regular dining plate. She was served grits and chopped sausage with gravy. The food was mixed together and placed on the back half of the plate. The resident had consumed approximately one-half			M0500			

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M0500	Continued from page 5 of the breakfast meal but stated she had consumed all of it. When asked about her vision, the resident stated she was blind. Resident #62 stated she had requested that her food items be served in individual bowls because it was easier for her to scoop out the food. She stated whether the kitchen sent her meal in bowls depended on who was working and said, "Sometimes they do and sometimes they do not." An observation and interview with Certified Nurse Aide (CNA) #2 on 9/15/26 at 8:47 AM confirmed Resident #62 was not served her breakfast in individual bowls according to her preference. CNA #2 stated the resident had made her request known a long time ago and the kitchen was aware of it. She stated the kitchen did not always provide the bowls. CNA #2 stated the bowls made it easier for the resident to feed herself and feel more independent. An interview with the Activity Assistant on 9/15/26 at 4:10 PM revealed Resident #62 loved attending church services but did not attend very often. She stated that, during the previous month, the resident attended approximately five minutes at the end of one program. She stated she had spoken with all staff on the floor, including nurses and aides, and asked them to get the resident up, but staff continued to ignore the resident's request. She stated it was important for residents to make choices about their care and that the facility should try to honor those preferences. Record review of Resident #62's August through September 2026 "Group Activity Log" revealed the resident was documented as attending church services on 8/5/26 and 8/19/26 and a music performance on 8/20/26. An interview with the Assistant Dietary Account Manager on 9/16/26 at 3:10 PM confirmed the dietary department was aware that Resident #62 had requested that her food items be served in individual bowls. She stated the cook knew to prepare the food in bowls. However, the preference was not listed on the meal ticket to inform the staff member preparing the meal tray. She confirmed the resident's preference for bowls should be honored. An interview with Licensed Practical Nurse (LPN) #3 on 9/17/26 at 8:15 AM revealed staff tried to honor Resident #62's preference to get up for activities. However, the facility was sometimes short-staffed and were not always able to get her up. Record review of the "Admission Record" revealed Resident #62 was admitted to the facility on 5/24/25			M0500			

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M0500	Continued from page 6 with diagnoses that included End Stage Renal Disease, Dependence on Renal Dialysis, Paraplegia, and Unspecified Visual Loss. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/29/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated Resident #62 was cognitively intact. Section GG documented that the resident was dependent for chair/bed-to-chair transfers (helper does all the effort). Resident #85 An observation outside Resident #85's door on 9/15/2026 at 8:30 AM revealed Resident #85 stating, "Can I please get a cup of coffee?" Certified Nurse Aide (CNA) #1 stated, "No, you know you can't have any coffee." Resident #85 once again stated, "Please, I just want a cup of coffee." CNA #1 stated, "She's always asking for a cup, and she knows she can't have it." CNA #1 abruptly left the room. During an interview on 9/15/2026 at 8:35 AM, the Assistant Director of Nursing (ADON) stated, "Yeah, she can't have any coffee because it makes her bowels run off." The ADON further acknowledged I guess we could give her something for diarrhea when it happens. She acknowledged that the residents' wishes were not honored and they should have been. During an interview on 9/16/2026 at 9:45 AM, the Director of Nurses (DON) revealed it is our expectation that all of our residents are treated with dignity and respect. She confirmed Resident #85 should have been given a cup of coffee, and if it was harsh on her stomach, it could have been explained to her, and she could have been given the choice of whether she wanted the coffee or not. She confirmed Resident #85 was able to make her own decisions. During an interview on 9/16/2026 at 3:45 PM, the Administrator revealed that Resident #85's wishes should have been honored. If the coffee doesn't agree with her stomach, then it should be explained to her, and then she should be allowed to make that decision. It's not our decision to make for her. Record review of the "Admission Record" revealed Resident #85 was admitted to the facility on 1/25/19 with diagnoses that included Systolic Congestive Heart Failure and Unspecified protein-calorie malnutrition.			M0500			

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M0500	Continued from page 7 A record review of the MDS, with an ARD of July 15, 2026, revealed a BIMS summary score of 13 under Section C, indicating Resident #85 was cognitively intact. Grievances Resident #46 Review of the facility policy titled "Filing Grievances/Complaints" latest review 4/3/26, revealed under "Policy Interpretation and Implementation: ... 7. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the Administrator within 72 hours of receiving the grievance and/or complaint.... 11. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed verbally and in writing (if requested) of the findings of the investigation and the actions that will be taken to correct any identified problems." An interview with Resident #46 on 9/14/26 at 11:12 AM stated that his wallet had been missing for months. He stated the wallet contained \$30, his photo identification, and a credit card. He stated he knew the wallet contained a \$20 bill but was unsure whether the remaining \$10 consisted of one \$10 bill or two \$5 bills. Resident #46 stated staff knew the wallet was missing but did nothing to locate it. Record review of Resident #46's "Grievance" dated 5/29/26 revealed, "On 5/28/26, Mr. (Proper last name of the resident) states that his wallet was missing, he says that he went to take a shower and left his wallet in his wheelchair. When he returned the wheelchair was gone and he was not able to find his wallet. He also states that the wallet contained maybe \$10 (dollars) and a credit card. A summary of the pertinent findings and conclusions revealed the Administrator has spoken with the resident on two different occasions regarding his misplaced item. The room has been searched, and clothes have been looked through. The wallet and the \$10.00 will be replaced." The Administrator marked the grievance as resolved on 6/03/26. Record review of Resident #46's Resident Trust Fund Account Statement with transaction dates from 6/1/26 through 9/15/26 revealed no evidence that the promised replacement money was credited to his account.			M0500			

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M0500	Continued from page 8 An interview with the Administrator (ADM) on 9/16/26 at 8:48 AM revealed she had spoken with Resident #46 and filed a grievance regarding his missing wallet. The ADM stated the resident reported the wallet contained \$10 and a credit card. She stated she thought they (the facility) had replaced the money and the wallet but confirmed neither had been replaced. She stated grievances should be resolved timely and that this grievance was overlooked. Record review of the "Admission Record" revealed Resident #46 was admitted to the facility on 11/01/25 with a diagnosis that included Malignant Neoplasm of the Prostate. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/05/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #46 was moderately cognitively impaired.		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 II Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide necessary assistance with activities of daily living (ADLs), including incontinence care and personal grooming, for four (4) of 11 residents reviewed for ADL care, Residents #4, Resident #50, Resident #59, and Resident #72. Findings Include: Review of the facility policy titled, "Activities of Daily		M0610				

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M0610	Continued from page 9 Living (ADL), Supporting" with a revised date of March 2018 revealed, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 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..." Resident #4 An observation of Resident #4 on 9/14/26 at 10:48 AM revealed he was lying in bed wearing a hospital gown with three to four dark brown, circular stains of various sizes on the chest area of his gown. His fingernails on both hands were approximately five-eighths (5/8) inches long and had a dark brown substance underneath them. An observation and interview with Licensed Practical Nurse (LPN) #5 on 9/15/26 at 3:15 PM revealed Resident #4 was wearing a soiled gown and had long fingernails with a dark substance underneath them. LPN #5 stated nurse aides were responsible for providing daily personal hygiene care, including cutting and cleaning the resident's fingernails and changing his gown when it was soiled. LPN #5 stated the resident could scratch himself and sustain a skin injury. An observation and interview with the Director of Nursing (DON) on 9/15/26 at 3:26 PM revealed she expected nurse aides to provide daily personal hygiene care, including changing the resident's gown when it was soiled and cleaning and cutting his fingernails. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 1/14/25 with a medical diagnosis of Alzheimer's Disease. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/05/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 9, which indicated Resident #4 was moderately cognitively impaired. Section GG revealed the resident was dependent on staff for personal hygiene. Resident #50 Record review of the MDS with an ARD of 9/3/2026 revealed under, Section GG, Resident #50 was dependent on staff for toileting hygiene.			M0610			

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M0610	Continued from page 10 During an interview on 9/14/2026 at 4:12 PM, Resident #50 stated he had not received incontinent care since getting up at approximately 11:00 AM that morning. During a follow-up observation at 4:30 PM, Resident #50 was sitting outside his room door and a staff member asked if he was ready to go to bed. Resident #50 responded, "Yes ma'am." During an interview on 9/15/2026 at 9:00 AM, Resident #50 stated he was not assisted to bed until approximately 8:20 PM last night and did not receive incontinent care until that time. He stated he did not receive incontinent care again until approximately 2:30 AM. During an interview on 9/15/2026 at 9:26 PM, Resident #50 stated he had not received incontinent care or been changed since approximately 2:30 PM that day. During an observation and interview on 9/15/2026 at 9:32 PM, LPN #6 pulled back Resident #50's brief and revealed the resident was wearing two briefs, a green brief underneath a white brief. Upon further observation, the green brief was saturated with urine to the top of the brief. LPN #6 confirmed the brief was saturated with urine. During an observation and interview on 9/15/2026 at 9:44 PM, Certified Nursing Assistant (CNA) #3 removed Resident #50's briefs. Observation revealed the green brief was fully saturated with urine from front to back, and the white brief contained a small amount of urine in the center. Observation of Resident #50's buttocks revealed no skin concerns. CNA #3 stated that after receiving her assignment at the beginning of her shift, she asked Resident #50 if he was wet, and the resident stated he was not. CNA #3 stated she had not provided incontinent care to Resident #50 at any time during her shift. She stated residents should be checked during rounds every two hours and confirmed she had not completed the required two-hour rounds for Resident #50 during her shift. During an interview on 9/16/2026 at 3:20 PM, the Director of Nursing (DON) stated her expectation was for residents to be checked at least every two hours and as needed. She stated it was unacceptable for Resident #50 to have been left unchecked for the reported length of time and he should not have had two briefs on. The DON stated she had previously received complaints from Resident #50 regarding not being changed timely and had provided staff in-services regarding checking residents and providing care every two hours.	M0610					

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M0610	Continued from page 11 Record review of "Admission Record" revealed Resident #50 was admitted to the facility on 3/25/2024 with diagnoses of Fusion of Spine, Cervical Region and Spinal Stenosis, Cervical Region. Record review of MDS with an ARD of 9/3/2026 revealed under Section C, a BIMS summary score of 15, indicating Resident #50 was cognitively intact. Resident #59 An observation on 9/14/26 at 11:06 AM revealed Resident #59 was lying in bed and did not respond to verbal stimuli. He appeared unkempt, with uncombed, oily hair and long gray facial hair measuring approximately five-eighths (5/8) inches in length. An observation and interview with LPN #5 on 9/15/26 at 3:18 PM revealed Resident #59 was scheduled to receive a bath during the day shift on Tuesday, Thursday, and Saturday. LPN #5 confirmed the resident had not been bathed or shaved, and his hair had not been washed in awhile it appeared. An interview with the DON on 9/15/26 at 3:30 PM revealed she expected Resident #59 to receive all personal hygiene care on his scheduled bath days. She confirmed residents should be clean and well groomed. Record review of the "Admission Record" revealed the facility admitted Resident #59 on 2/25/26 with medical diagnoses that included Cerebral Infarction due to Embolism of Left Carotid Artery. Record review of the MDS with an ARD of 9/08/26 revealed under Section C, a BIMS summary score of 6, which indicated Resident #59 was severely cognitively impaired. Section GG revealed the resident was dependent on staff for bathing and personal hygiene. Resident #72 An observation and interview on 9/14/2026 at 3:25 PM revealed Resident #72 had approximately one-half (1/2) inch long facial hair on her chin and she stated, "I don't like this hair on my face." An observation and interview on 9/15/2026 at 8:25 AM revealed, upon entering Resident #72's room, a foul odor was present. Resident #72 was sitting on			M0610			

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M0610	Continued from page 12 the side of her bed eating breakfast. An incontinence brief was observed lying on the floor beside the resident's bed. The brief was heavily saturated with urine and soiled with a brown substance. Resident #72 stated, "My diaper was so heavy it fell off of me." Resident #72's facial hair remained unchanged from the previous day. During an interview and observation on 9/15/2026 at 8:40 AM, the Assistant Director of Nurses (ADON) confirmed Resident #72's brief was lying on the floor beside her bed and was heavily saturated with urine and a brown substance. The ADON acknowledged the condition of the brief indicated the resident appeared not to have been changed in a while. During an interview on 9/15/2026 at 2:15 PM, the DON stated the ADON had informed her that Resident #72's brief was found on the floor. The DON stated that if the brief was so saturated that it fell off the resident, then the resident had obviously not been changed as she should have been during the night. The DON further stated she had received complaints from day-shift staff on a few occasions regarding residents being found heavily soiled at the beginning of the shift. The DON stated the nurse aides were responsible for providing residents' ADL care, including bathing, toileting, and shaving facial hair according to residents' preferences. An observation and interview on 9/15/2026 at 2:35 PM revealed Resident #72 continued to have approximately one-half (1/2) inch long facial hair on her chin and stated, "Yeah, they haven't taken care of my shaving." During an observation and interview on 9/15/2026 at 4:35 PM, Resident #72 was observed sitting in the designated smoking area with approximately one-half (1/2) inch long facial hair remaining on her chin. The Administrator observed Resident #72 and confirmed the presence of the facial hair. The Administrator stated, "She is not adequately groomed, and this is not acceptable." Record review of "Admission Record" revealed Resident #72 was initially admitted to facility on 8/13/2025 with diagnoses which included Major Depressive Disorder, Cerebral Infarction, and unspecified Dementia. Record review of MDS with an ARD of 8/8/2026 revealed under Section C, a BIMS summary score of 09, indicating Resident #72 was moderately cognitively impaired.			M0610			

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M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident 's clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to identify and assess an indwelling urinary catheter following a resident's return from the hospital, clarify the catheter's continued clinical necessity and obtain appropriate orders, and provide catheter care and monitoring for eight (8) days for one (1) of 10 residents with an indwelling urinary catheter. (Resident #35). Findings include: Review of the facility policy titled "Catheter Care, Urinary," revised 3/3/2026, revealed, "...Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given...3. All assessment data obtained when giving catheter care...4. Character of urine...5. Any problems noted at the catheter/urethral junction..." During an initial observation on 9/14/2026 at 12:31 PM, Resident #35 was observed in bed with an indwelling urinary catheter drainage bag attached to the bed rail. Resident #35 stated he got it while he was in the hospital recently. Record review of Resident #35's History and Physical dated 8/28/2026 revealed, "He was sent from (proper name of hospital) for urinary obstruction due to urinary retention. Outside Emergency Room (ER) placed with Foley and had a total of four (4) liters (L) of urine output." Record review of Resident #35's Order Summary Report of active orders as of 9/15/2026 revealed no physician order for the indwelling urinary catheter, catheter care, catheter monitoring, or urine-output monitoring. Record review of Resident #35's Treatment Administration Records, Medication Administration	M0620					

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M0620	Continued from page 14 Records, progress notes, and care plan from 9/7/2026 through 9/15/2026 revealed no documented catheter care or catheter assessment. The only documentation related to output during the eight-day period was a General Progress Note dated 9/9/2026 at 11:01 PM, which documented, "Output-450." The note did not identify the source of the output, the unit of measurement, or include an assessment of the catheter, urine characteristics, catheter patency, tubing, drainage bag, insertion site, or signs and symptoms of urinary tract infection. During an interview and concurrent record review on 9/15/2026 at 3:58 PM, the Director of Nursing (DON) stated she was unaware that Resident #35 had returned from the hospital on 9/7/2026 with an indwelling urinary catheter. The DON confirmed that the admitting nurse documented the presence of the catheter but did not enter orders for the catheter or catheter care. The DON further confirmed that, because no orders had been entered, Resident #35 had not received catheter care or monitoring from 9/7/2026 through 9/15/2026. The DON stated she expected the admitting nurse to contact the physician to determine whether the catheter should be continued and obtain appropriate orders, or to verify that the hospital discharge documentation contained a diagnosis or clinical indication supporting continued catheter use. During an interview and concurrent record review on 9/15/2026 at 4:04 PM, the DON identified a follow-up appointment scheduled for 9/22/2026 in Resident #35's hospital discharge paperwork. The DON confirmed that the appointment had not been entered into the resident's orders or appointment schedule. The Assistant Director of Nursing (ADON) stated that Resident #35 had an appointment with (proper name of facility) but acknowledged that she had not entered an order for the appointment and had not been aware of the appointment before the record review. Record review of Resident #35's Admission Record revealed the resident was originally admitted to the facility on 8/20/2026 with diagnoses that included age-related osteoporosis with current pathological vertebral fracture, subsequent encounter for fracture with routine healing. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/13/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 14 under Section C, which indicated Resident #35 was cognitively intact.			M0620			

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M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide services to maintain a resident's range of motion as evidenced by failure to apply a hand splint as ordered for one (1) of three (3) residents reviewed for range of motion (ROM). Resident #6 Findings Include: Review of the facility policy titled "Contracture Management Program" revised 3/4/26 revealed, "Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of range of motion..." Resident #6 Record review of Resident #6's "Order Summary Report" revealed an order dated 5/26/26, "Resident to have left WHFO (wrist-hand-finger orthosis) to treat contracture to be worn 8 (eight) hours daily or to resident tolerance. To be applied by nursing after breakfast and removed before supper. Nursing to check skin and report any changes." An observation and interview with Resident #6 on 9/14/26 at 11:25 AM revealed he was sitting in his motorized wheelchair in his room. His left fingers were contracted and bent inward toward his palm. Resident #6 stated he had a hand splint in his dresser drawer that he was supposed to wear, but staff did not apply it. Record review of Resident #6's "Occupational Therapy (OT) Discharge Summary" dated 11/13/25 revealed under "Functional Maintenance: Pt (patient) to have L (left) WHFO (wrist-hand-finger orthosis) to treat contractures to be worn up to 8 (eight) hrs. (hours) per pt (patient) tolerance and applied by nsg (nursing)." An interview with the Director of Nursing (DON) on 9/15/26 at 3:31 PM revealed she expected the aides to apply the splints and the nurses to ensure this was completed. The DON stated the splint was listed in the task section/Kardex so the aides would know	M0625					

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M0625	Continued from page 16 when to apply it. She confirmed the resident's contractures could worsen if the splint was not applied as ordered. Record review of Resident #6's September 2026 "Task" revealed the left-hand splint was listed as PRN (as needed), which did not match the order for daily use. The record contained no documentation or staff initials showing the splint was applied any during September 2026. Record review of the "Admission Record" revealed Resident #6 was admitted to the facility on 9/04/25 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Muscle Wasting and Atrophy, and Contracture, Left Hand." Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/9/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated Resident #6 was cognitively intact.		M0625				
M0735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress		M0735				

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M0735	Continued from page 17 notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on resident interview, staff interviews, record review and facility policy review, the facility failed to maintain a complete and accurately documented clinical record for administration of a prescribed physicians order one (1) of twenty-six (26) sampled residents reviewed for clinical records. Resident #9 Findings Include: Review of facility policy titled, "Medication Administration," dated 03/05/26, stated, "To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice." Record review revealed a physician's order dated 9/09/2026 at 3:00 PM for Sodium Chloride Solution 0.9% intravenously (IV) at 50 milliliters (mL) per hour every shift for low sodium for one day. Record review of the September 2026 Medication		M0735				

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M0735	Continued from page 18 Administration Record (MAR) revealed the IV therapy was documented by nursing for 9/09/2026 on the evening shift. The MAR contained no documentation of administration/continuation of the ordered IV therapy for the night shift on 9/09/26 and the day shift 9/10/26. Further review of the clinical record revealed no documentation to verify the ordered IV infusion continued at 50 mL/hr. throughout the prescribed treatment period. During an interview on 9/15/2026 at 9:05 AM, Resident #9 stated he thought he received the sodium IV on all three shifts. On 9/16/2026 at 2:00 PM, the Assistant Director of Nursing (ADON), stated she initiated the IV infusion and that the charge nurses were to document the subsequent shifts. During an interview on 9/16/2026 at 2:05 PM, the Administrator stated that if the care was not documented, it was considered not done and it is the expectation of the facility for nurses to sign the MAR when IV medication is administered to accurately reflect what medication Resident #9 received. Record review of Resident #9's "Admission Record" revealed the resident was admitted to the facility on 1/05/2026 with diagnosis that included Post-Traumatic Stress Disorder (PTSD). Record review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/09/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.		M0735				
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism		M1570				

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M1570	Continued from page 19 to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review and facility policy review, the facility failed to maintain an effective infection prevention and control program by failing to ensure staff wore gowns in accordance with Enhanced Barrier Precautions (EBP) during the use of indwelling medical devices for (Resident #26 and Resident #53) and maintain sterile technique during tracheostomy care for (Resident #5); and properly contain and handle soiled linen and/or soiled briefs to prevent potential cross-contamination for (Resident #25 and Resident #50) for five (5) of the 26 sampled residents. Findings Include: Review of the facility's policy titled "Enhanced Barrier Precautions," reviewed 3/19/25, revealed, "Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities... EBP are indicated for residents with any of the following: ...Wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO) Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies..." Review of facility policy titled "Infection Prevention and Control Program" revised 9/16/2026 revealed, "An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections..." Resident #5			M1570			

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M1570	Continued from page 20 Record review of facility policy titled "Tracheostomy Care" reviewed 6/24/2025 revealed under, "1. Aseptic technique must be used." Record review of "Order Summary Report" revealed an order dated 8/8/24 , "Tracheostomy care every shift and prn (as needed) using aseptic technique. Remove inner cannula, clean with half strength H2O2 (hydrogen peroxide) and sterile H2O (water), dry with sterile gauze and cotton swab. Re-insert inner cannula, turn to lock. Clean outer cannula/stoma with sterile H2O, rinse with sterile H2O, pat dry with sterile gauze. May use split sterile gauze PRN. Two times a day." Observation on 9/15/2026 at 3:01 PM revealed the Certified Respiratory Therapist (CRT), Respiratory Director, performed tracheostomy care for Resident #5. The CRT performed hand hygiene, cleaned the bedside table, placed a red disposal bag at the end of the table, and checked the resident's oxygen saturation. Resident #5 was lying supine in bed with the head of the bed elevated and displayed no signs or symptoms of respiratory distress. The CRT donned regular gloves and disconnected the resident's tubing. The CRT prepared supplies for the procedure. The CRT contaminated the protective sheet when removed from the tracheostomy care kit. He held up the sheet and shook it open making it come in contact with the bedside table. While donning sterile gloves, the CRT contaminated the sterile gloves when the right glove came into contact with the opposite hand and the left glove came into contact with the bedside table. The CRT removed the resident's cannula and gauze dressing, removed his gloves, and performed hand hygiene. The CRT donned regular gloves, obtained peroxide-soaked gauze, and cleansed around the tracheostomy site. No redness, drainage, or other concerns were observed at the tracheostomy site. The CRT removed his gloves, performed hand hygiene, and donned sterile gloves. During application of the sterile gloves, the CRT contaminated the right sterile glove when it came into contact with his left hand. The CRT subsequently used his right hand to insert a new cannula. The CRT removed his gloves, performed hand hygiene, and donned another pair of sterile gloves. During application, the right sterile glove again became contaminated when it came into contact with his left hand. The CRT then placed new gauze around the tracheostomy site. The CRT checked Resident #5's oxygen saturation, which was 95%, and reconnected the resident to the respiratory equipment. The CRT then stated he had forgotten to cleanse the tracheostomy site with saline-soaked		M1570				

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M1570	Continued from page 21 gauze. The CRT removed the newly placed dry gauze, cleansed around the tracheostomy site with saline-soaked gauze, removed his gloves, performed hand hygiene, donned sterile gloves, replaced the dry gauze, and reconnected the resident's respiratory equipment. Resident #5 displayed no signs or symptoms of respiratory distress during or immediately following the procedure. During an interview on 9/15/2026 at 3:20 PM, the Certified Respiratory Therapist (CRT), Respiratory Director, confirmed tracheostomy care required sterile technique and stated that a break in sterile technique increased the resident's risk for infection. The CRT stated the available sterile gloves were too small for his hands, making it difficult for him to put on the gloves without contaminating them. During an interview on 9/16/2026 at 2:30 PM, the Infection Preventionist (IP) confirmed tracheostomy care was a sterile procedure. The IP stated that a break in sterile technique during tracheostomy care was an infection-control concern. Record review of "Admission Record" revealed Resident #5 was admitted to facility on 8/7/2024 with a diagnosis of Anoxic Brain Damage, Not Elsewhere Classified. Resident #25 During an observation on 9/14/2026 at 4:24 PM, a soiled flat sheet was observed lying directly on the hallway floor outside Resident #25's room and was not contained in a bag. A red biohazard bag containing Resident #25's personal clothing was observed on top of the soiled sheet. During the observation, multiple staff members, including one Certified Nursing Assistant (CNA) and one nurse, walked past the soiled linen without removing it from the floor. CNA #3 removed linen from a clean linen cart and left the protective cover open, exposing the clean linens. The clean linen cart was approximately one doorway away from the soiled linen on the hallway floor. During an interview on 9/14/2026 at 4:35 PM, Licensed Practical Nurse (LPN) #6 confirmed a soiled sheet was on the hallway floor. LPN #6 stated Resident #25 had told her that his soiled linen needed to be removed. She confirmed she did not remove the linen at that time and then observed Resident #25 place the linen in the hallway. LPN #6 stated the soiled linen should have been removed from the hallway and placed in the appropriate linen barrel immediately. She also confirmed the			M1570			

Mississippi State Department of Health

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M1570	Continued from page 22 protective cover on the clean linen cart should remain closed. LPN #6 stated that leaving soiled linen on the floor and leaving the clean linen cart open were infection control concerns. During an interview on 9/16/2026 at 2:13 PM, the Infection Preventionist stated Resident #25 was on EBP due to colonized Candida auris. The IP stated EBP did not require the use of red biohazard bags for Resident #25's linen or trash; however, the facility used the bags to reduce the risk of spreading Candida auris. She stated the biohazard bags alerted staff that the contents were considered contaminated and should be handled accordingly. The IP stated staff should remove trash and soiled linen from Resident #25's room at least once every shift and as needed. She stated soiled linen should never be placed on the floor, and staff should have immediately removed the soiled linen that was observed on the floor. The IP confirmed that placing soiled linen on the floor and failing to remove it immediately were infection control concerns. Record review of "Admission Record" revealed Resident #25 was admitted to facility on 4/24/2025 with a diagnosis of Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy without Gangrene. Resident #26 An observation on 9/16/26 at 8:10 AM, revealed LPN #1 administered medications to Resident #26 through the resident's Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 wore gloves but did not wear a gown during the medication administration. During an interview on 9/16/26 at 10:50 AM, LPN #1 confirmed the resident was under EBP due to having the peg tube and a wound. LPN #1 acknowledged she was required to wear a gown while administering the medications through the peg tube and stated, "She had forgotten to put on the gown." A record review of the facility "Admission Record" revealed Resident #26 was admitted to the facility on 06/25/2026 with diagnoses that included Spastic Quadriplegic Cerebral Palsy, Gastrostomy Status, and unspecified Convulsions. A record review of the Minimum Data Set Section C with an Assessment Reference Date (ARD) of 7/7/26 revealed a Brief Interview of Mental Status (BIMS) score of 99 which indicated Resident #26 was unable to complete the interview.			M1570			

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M1570	Continued from page 23 Resident #50 During an observation and interview on 9/15/2026 at 9:44 PM, CNA #3 removed two soiled briefs from Resident #50. Observation revealed the green brief was saturated with urine from front to back, and the white brief contained a small amount of urine in the center. CNA #3 placed the soiled briefs directly on the floor and stated she did not know what to do with the soiled briefs because she did not have a bag available. CNA #3 confirmed that placing the soiled briefs on the floor was an infection control concern. During an interview on 9/16/2026 at 2:12 PM, the Infection Preventionist stated CNA #3 should have placed the soiled brief directly into a bag after removing it from the resident. The IP stated placing a soiled brief on the floor was an infection control concern because staff could walk through the area and track contamination to other areas of the facility, increasing the risk of spreading infection. Record review of "Admission Record" revealed Resident #50 was admitted to facility on 3/25/2024 with diagnoses of Fusion of Spine, Cervical Region and Spinal Stenosis, Cervical Region. Resident #53 An observation on 9/16/26 at 8:55 AM, revealed LPN #3 administered medications to Resident #53 through the resident's PEG tube. LPN #3 wore gloves but did not wear a gown during the medication administration. During an interview on 9/16/2026 at 10:55 AM, LPN #3 confirmed Resident #53 had a PEG tube and was under EBP. LPN #3 acknowledged she failed to wear a gown while administering the resident's medications through the PEG tube. A record review of the facility "Admission Record" revealed Resident #53 was admitted to the facility on 04/11/2025 with diagnoses that included Cerebral Infarction, Encounter for attention to Gastrostomy, and Dysphagia. A record review of the MDS Section C with an ARD of 8/4/26 revealed a BIMS score of 06, which indicated Resident #53 had severe cognitive impairment. During an interview on 9/16/2026 at 11:15 AM, the Director of Nursing (DON) confirmed Resident #26 and Resident #53 were under Enhanced Barrier		M1570				

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M1570	Continued from page 24 Precautions due to having PEG tubes. The DON stated staff were required to wear gowns and gloves when providing care requiring Enhanced Barrier Precautions to reduce the potential transmission of infection. During an interview on 9/17/2026 at 11:30 AM, the Infection Preventionist stated she had recently provided staff education regarding Enhanced Barrier Precautions and the staff were aware that they should have worn a gown. The IP confirmed that staff were expected to wear gowns and gloves when providing medications through the PEG tube and for residents under Enhanced Barrier Precautions to reduce the potential transmission of infection.			M1570			