MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22CI	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CEN	**1966 HILL DRIVE GRENADA, MS 38901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments A Complaint Investigation (CI) was conducted 7/12/21-7/15/21 by the State Agency (SA). Complaints investigated were #17840, #17578, #17507, #17524, #17023 and #17001. The facility was found to be in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. No deficiencies were cited. The allegations were neglect, resident rights, Quality of Care, Pressure sore prevention, Following MD orders, Misappropriation of property, staffing, Injury of unknown origin, RP notifications.	M 000		

Mississippi State Department of Health

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