STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255173	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Trace Health and Rehabilitation	555 John R. Junkin Drive Natchez, MS 39120

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that were accurately documented for one (1) of eight (8) sampled residents. Resident #1.Findings include:Record review of the admission Record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, schizoaffective disorder-bipolar type with onset date 11/02/22 (upon admission). There was no diagnosis of dementia included. Record review of the Social Service Progress Review for Resident #1 dated 7/07/2023 revealed that the resident had impaired daily decision making with described impairment listed as resident has dementia. Record review of the Social Service Progress Review for Resident #1 dated 2/02/2024 revealed the that the resident had impaired daily decision making with described impairment listed as resident has dementia.Record review of the Social Service Progress Review for Resident #1 dated 6/11/2024 revealed the assessment indicated that the resident had impaired daily decision making with described impairment listed as resident has dementia and is manic depressive.On 8/25/25 at 8:15 AM, an interview with the Complainant revealed she had concerns related to Resident #1 had not received appropriate assessment, diagnostic tests or diagnosis while a resident at the facility, therefore rendering her care not appropriate for her actual condition, which she alleged was not discovered until she had discharged from the facility, spent a month at a different facility where she suffered a severe fall and head trauma and then spent a number of days at a third facility where she suffered a second severe fall with additional head trauma. She stated that she was in no way alleging that Resident #1 had not suffered from psychiatric illness of schizoaffective disorder-bipolar type but instead said that it was her belief that she also suffered from frontotemporal dementia. She stated that she was confused because after Resident #1 discharged from the facility she obtained a copy of her entire medical record and noted three (3) documents, specifically social services review notes, which clearly stated that the resident had dementia.On 8/26/25 at 5:17 PM, during a telephone interview with the former Social [NAME] Director (SSD), she stated that she was aware but concerned that Resident #1 showed signs of dementia and discussed this with the interdisciplinary team (IDT). She confirmed that she was aware that the resident had multiple head CT scans during her residence at the facility. She confirmed that she had documented that the resident had dementia in her notes throughout Resident #1's residence at the facility. She stated that the documentation was in error and said she thought she had inaccurately documented the resident's diagnosis of dementia and manic depression because, maybe I thought I heard someone say that. She confirmed that she had not reviewed Resident #1's diagnosis list or medical record to ascertain her actual diagnoses. On 8/27/25 at 3:30 PM, during a telephone interview the primary healthcare provider (physician) confirmed that Resident #1 was admitted by the facility with diagnosis of schizoaffective disorder-bipolar type. He said the during Resident #1's stay at the facility he received regular reports from his Nurse Practitioner (NP) and that the resident's behaviors were in line with the signs and symptoms of her diagnosis. He confirmed that the signs and symptoms exhibited by Resident #1 were also associated with frontotemporal dementia and that usually radiographic study may reveal the differential diagnosis. He confirmed that the resident had multiple head CT scans during her residence at the facility, read by a radiologist with no noted change or addition to the diagnosis she had at the time of admission by the facility. He stated that if he had been made aware of a new diagnosis the treatment would not have changed, because the treatments are basically the same in as much as the symptoms/behaviors were targeted and treated the same. He stated that he did not believe that the resident was inappropriately placed and said that her preexisting diagnosis would have limited her appropriateness for dementia or memory care units. He stated that since the resident had been diagnosed with impaired cognition of unknown etiology, the facility care planned and provided care in the same manner to a resident who had an official dementia diagnosis. On 8/27/25 at 4:30 PM, during an interview the Director of Nursing (DON) confirmed that Resident #1 did not have a diagnosis of dementia during her residence at the facility but did have a care planned diagnosis of impaired cognition. She confirmed that any documentation of dementia was inaccurate. She stated that resident diagnoses were listed in their entirety on each resident's admission record. She confirmed that it was important for documentation to be accurate for each resident in order for staff to provide appropriate patient centered care and that inaccurate documentation could result in care for the resident that was not directed towards the needs of the resident. On 8/27/25 at 5:00 PM, during an