STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255316	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove	11 Pecan Drive Columbia, MS 39429

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview, record review, and facility policy review, the facility failed to implement individualized care plan interventions for two (2) of six (6) sampled residents. Resident #1 and Resident #2.Findings include:A review of the facility's Total Care Plan Policy, undated, revealed, It is the policy of this facility that the Interdisciplinary care plan will be done as follows.Reminders.Care Plan must be followed by all staff included in resident's care.Resident #1A record review of the facility's document, Fall During Staff Assist, dated 4/3/26, revealed Resident #1 fell during a chair-to-bed transfer when Certified Nurse Aide (CNA) #1 used a sit-to-stand lift.A record review of the facility's Staffing Disciplinary, dated 4/3/26, revealed, .CNA.noted to not follow proper transfer status for resident (Resident #1).This write did a phone interview with CNA who states that she asked the resident how she transferred.Made CNA aware that the care profile and transfer status are to be looked at prior to the start of every shift.A record review of the Nurse Notes, dated 4/3/26 at 7:46 AM, revealed, .CNA reported to this nurse that resident was on the floor.Fall was witnessed by CNA. CNA asked resident if she was a total and resident reported, ?I can stand.' While using sit to stand lift, resident let go of handles on her way down and slid onto the floor.A record review of the Order Summary Report revealed a physician's order dated 2/16/26 for TOTAL LIFT X2 (with two person) ASSIST.A record review of the Care Plan Report revealed Resident #1 had a focus of fall risk with interventions including d/c sit to stand. Total lift x 2 assist.A record review of the Care Profile Report, dated 4/20/26, revealed Resident #1 had special instructions including TOTAL LIFT X2 CNAs FOR TRANSFERS.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident's cognition was moderately impaired.A record review of the Face Sheet revealed the facility admitted Resident #1 on 2/1/25 with diagnoses including Chronic Obstructive Pulmonary Disease.Resident #2Record review of the Care Plan Report revealed Focus: Falls-I have a history of falls prior to admission to facility with potential for reoccurrence to tremors, deconditioning, weakness, cognition. I require the use of bed and chair alarms related to fall risk. Date Initiated 10/24/24A record review of the facility's document, Un-witnessed Fall with Head Injury, dated 3/16/26, revealed Resident #2 was found on the floor of her room and the bed alarm was not sounding to alert staff.A record review of the Order Summary Report revealed Resident #2 had a physician's order dated 10/29/24 for BED/CHAIR ALARM.CHECK EVERY SHIFT FOR PROPER OPERATION & PLACEMENT.A record review of the Care Profile Report revealed Resident #2 had special instructions including use of a bed alarm.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/26 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident's cognition was severely impaired.A record review of the Face Sheet revealed the facility admitted Resident #2 on 10/24/24 with diagnoses including Dementia.On 4/20/26 at 10:10 AM, during an observation and attempted interview, Resident #2 was seated in her wheelchair at the nurses' station with a chair alarm in place. She was alert but unable to recall the fall incident.On 4/20/26 at 10:30 AM, during an observation and interview, Resident #1 was seated in her wheelchair in her room (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the call light within reach and denied complaints.On 4/20/26 at 2:25 PM, during an interview with the Director of Nursing (DON), she reported care plans were communicated to staff through Resident Care Profiles and confirmed Resident #1 required two (2) staff and a full mechanical lift for transfers.On 4/20/26 at 3:10 PM, during an interview with the Quality Assurance (QA) Nurse, he reported the root cause of Resident #1's fall was failure to follow the care plan requiring two (2) staff and a full mechanical lift. He reported Resident #2's fall occurred when the resident got out of bed and the bed alarm was not engaged, which could have alerted staff through the call light system.On 4/20/26 at 4:30 PM, during an interview with the Administrator, he reported staff were expected to implement care plans to meet resident needs and provide a safe environment.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a safe environment and implement interventions to prevent accidents for two (2) of six (6) residents reviewed with a history of falls. Resident #1 and Resident #2.Findings include:A review of the facility's Fall Protocol Policy, dated 2/2011, revealed, It is the policy of this facility that the fall protocol will be as follows.Fall review.Evaluate possible alternative interventions to help prevent falls.Resident #1A record review of the facility's document, Fall During Staff Assist, dated 4/3/26, revealed Resident #1 fell during a chair-to-bed transfer when Certified Nurse Aide (CNA) #1 used a sit-to-stand lift. A review of the facility's Staffing Disciplinary, dated 4/3/26 revealed .CNA.noted to not follow proper transfer status for resident (Resident #1).This write did a phone interview with CNA who states that she asked the resident how she transferred.Made CNA aware that the care profile and transfer status are to be looked at prior to the start of every shift.A record review of the Nurse Notes dated 4/3/26 at 7:46 AM for Resident #1, revealed .CNA reported to this nurse that resident was on the floor.Fall was witnessed by CNA. CNA asked resident if she was a total and resident reported, ?I can stand.' While using sit to stand lift, resident let go of handles on her way down and slid onto the floor.A record review of the Order Summary Report revealed a Physician's Order, dated 2/16/26 for TOTAL LIFT X2 (with two person) ASSIST.A record review of the Care Profile Report, dated 4/20/26, revealed Resident #1 had Special Instructions including TOTAL LIFT X2 CNAs FOR TRANSFERS.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. A record review of the Face Sheet revealed the facility admitted Resident #1 on 2/1/25 and she had diagnoses including Chronic Obstructive Pulmonary Disease.On 4/20/26 at 10:30 AM, during an observation and interview, Resident #1 was seated in her wheelchair in her room with the call light within reach. She was unable to recall the fall and denied complaints.Resident #2A record review of the facility's document Un-witnessed Fall with Head Injury, dated 3/16/26, revealed Resident #2 was found on the floor of her room and the bed alarm was not sounding to alert staff. Prior to the fall, the resident was lying in the bed.A record review of the Order Summary Report revealed Resident #2 had a Physician's Order, dated 10/29/24 for BED/CHAIR ALARM.CHECK EVERY SHIFT FOR PROPER OPERATION & PLACEMENT.A record review of the Care Profile Report revealed Resident #2 had Special Instructions including Bed Alarm to bed.A record review of the Comprehensive MDS with an ARD of 4/8/26 revealed Resident #2 had a BIMS score of five (5), which indicated her cognition was severely impaired.A record review of the Face Sheet revealed the facility admitted Resident #2 on 10/24/24 with diagnoses including Dementia. On 4/20/26 at 10:10 AM, during an observation and attempted interview, Resident #2 was seated in her wheelchair at the nurses' station with a chair alarm in place. She was alert and responsive but unable to recall the fall incident.On 4/20/26 at 2:25 PM, during an interview with the Director of Nursing (DON), she reported Resident Care Profiles were available to all nursing staff and confirmed Resident #1 required two (2) staff and a full mechanical lift for transfers. She reported she was not as familiar with Resident #2's fall.On 4/20/26 at 3:10 PM, during an interview with the Quality Assurance (QA) Nurse, he reported the root cause of Resident #1's fall was failure to follow the care profile requiring two (2) staff and a full mechanical lift. He reported Resident #2's fall occurred when the resident got out of bed without assistance and the bed alarm was not engaged, which could have alerted staff through the call light system and allowed for intervention.On 4/20/26 at 4:30 PM, during an interview with the Administrator, he reported the expectation was for staff to provide a safe environment and prevent accidents and confirmed the facility investigated both incidents.