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	02/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and facility policy review, the facility failed to sanitize pots and pans according to manufacturer's guidelines and failed to calibrate food thermometers to ensure food remained hot for one (1) of four (4) kitchen observations.Findings include:A review of the facility's Calibration of Thermometers Policy, revised 10/17, revealed, .Facility shall ensure that a thermometer gives accurate recordings. Procedure: 1. All thermometers are to be calibrated: a. Before each use b. After being dropped c. When experiencing an extreme change in temperature. A review of the facility's Manual Warewashing Policy, dated 10/17 revealed, .Food service pots and pans that cannot fit in the dish machine or cleaned and sanitized in a three-compartment sink.Procedure.5) Third Compartment Sink a) Fill the third sink with water and sanitizer to the correct concentration. Hot water can be used as an alternative. B) Immerse items in the third sink in hot water or chemical sanitizing solution. I)If hot water immersion is used, the water must be a minimum of 171 F and items must be immersed for 30 seconds. Ii) If chemical sanitizing is used, the sanitizer must be mixed to the proper concentration. Follow manufacturers' recommendations. The following are published guidelines. (1) Chlorine-Immerse for 7 seconds in water temperature 100 degrees F (Fahrenheit) (2) Iodine-Immerse for 30 seconds in water temperature 68 degrees F. (3) Quats-Immerse for 30 seconds in water temperature 75 degrees F. (6) The concentration of the sanitizing solution is checked with an appropriate test kit when the sink is filled and again if the solution is used for an extended period of time.On 2/10/26 at 10:35 AM, during an observation, the Dietary Manager (DM) checked food temperatures on the steam table using a manual thermometer and failed to calibrate the thermometer prior to testing the food.On 2/10/26 at 10:48 AM, during an observation and interview, Dietary Aide (DA) #2 washed pots and pans in the three-compartment sink. Pots and pans were observed air drying on a table next to the sink. The third sink contained warm water, and a test strip did not register sanitizer concentration. DA #2 stated the sanitation equipment was not working. The sanitation container was observed to be under the sink without the sanitation tubing connected.On 2/10/26 at 10:48 AM, during an interview, the DM confirmed she failed to calibrate the thermometer because it had been calibrated previously by another cook and confirmed thermometers were not calibrated before each meal. The DM also confirmed the sanitation tubing had been disconnected from the three-compartment sink and was later reconnected to allow sanitizer to dispense into the sink.On 2/10/26 at 11:54 AM, during a follow up interview, DA #2 explained that while washing the pots and pans in the three-compartment sink, she did not initially add sanitizing solution to the sink and believed sanitizer may have already been present from earlier use.On 2/12/26 at 11:28 AM, during an interview, the Administrator stated staff are expected to calibrate thermometers and use sanitation equipment according to manufacturer guidelines.

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 0550 Level of Harm - Minimal harm or potential for 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, interview, record review, and facility policy review, the facility failed to ensure a resident's right to dignity, as evidenced by standing over the resident while assisting to feed for one (1) of (18) sampled residents. Resident #34.Findings include:A review of the facility's Dignity Policy, undated, revealed, .Dignity means that staff carry out activities which assist the resident to maintain and enhance his/her self-esteem and self-worth as follows.Promoting resident independence and dignity in dining.A record review of Resident #34's Face Sheet revealed the facility admitted Resident #34 on 7/16/12 with diagnoses including Hemiplegia and Hemiparesis.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of two (2), which indicated the resident's cognition was severely impaired.On 2/9/26 at 11:54 AM, during an observation, Certified Nursing Aide (CNA) #1 was observed assisting Resident #34 with feeding in the resident's room. She was standing over the resident during lunch. CNA #1 tilted her arm downward to place food into the resident's mouth. Two vacant chairs were present in the resident's room, and three chairs were located in the hallway adjacent to the resident's door.On 2/9/26 at 12:05 PM, during an interview, CNA #1 acknowledged she assisted Resident #34 with feeding while standing over the resident. She reported she was aware she was expected to feed residents while seated at eye level. She reported she was aware two chairs were available in the room, and three chairs were located in the hallway near the resident's door. She reported she did not sit because she had been told the chairs were for family members and affirmed no family members were present during the meal.On 2/11/26 at 11:29 AM, during an interview, the Director of Nursing (DON) reported the importance of sitting during feeding assistance was to improve positioning and reduce the likelihood of aspiration. She reported her expectation was for staff to sit when assisting residents with feeding.On 2/12/26 at 10:40 AM, during an interview, the Administrator reported standing over a resident during feeding was a dignity concern and disrespectful and stated his expectation was for staff to sit during assisted feedings.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to privacy and confidentiality by posting personal care information in the resident's room for one (1) of two (2) residents sampled for privacy. Resident #8.Findings include:A review of the facility's Privacy of Health Information Policy, undated, revealed, . It is the policy of this facility that resident's health information will be protected as follows: . No health information allowed on counter tops or in areas visible to unauthorized persons . - Posting notes and reminders in the residents' rooms by staff members will be prohibited (unless resident and/or responsible party has given us permission to do so AND it has been added to the resident's care plan) .A record review of Resident #8's Face Sheet revealed the facility admitted Resident #8 on 2/7/24 with diagnoses including Encounter for Attention to Gastrostomy.A record review of the Order Summary Report with active orders as of 2/10/26 revealed Resident #8 had physician orders for . All Oral Meds to Be Given Via percutaneous endoscopic gastrostomy (Peg) Tube as Previously Ordered (dated 1/2/26) . NPO (nothing by mouth) Status (dated 1/7/26) . Diet: Nutren 2.0 at 30 ml (milliliters) per hour continuous via PEG tube (dated 12/15/25) . Keep Head of Bed Elevated 30 Degrees or Greater at All Times R/T (related to) Peg Tube and Risk of Aspiration (dated 12/15/25) .On 2/11/26 at 9:31 AM, during an observation and interview, Licensed Practical Nurse (LPN) #3 was observed administering medications via PEG tube to Resident #8. Two (2) signs were observed posted on the wall above the resident's headboard indicating to Keep Head of Bed elevated at 30-45 degrees to prevent aspiration and Nutren 2.0 at 30 ml/hr (milliliters/hour) continuous via PEG tube and All meds given via PEG tube. LPN #3 confirmed the signs and reported the information reflected private health information contained in the resident's medical record and care plan.On 2/11/26 at 10:19 AM, during an interview, the Director of Nursing (DON) confirmed signage containing resident personal care information should not be posted in resident rooms. She reported Resident #8 recently received a new PEG tube due to decreased appetite and weight loss. She confirmed the information posted above the resident's headboard included personal care information and should not have been posted due to privacy concerns. She reported the information was available in the resident's medical record for staff access. She reported she was not aware the signs were posted and did not know who posted them or how long they had been posted. She stated her expectation was for staff to honor resident privacy and not post personal care information unless requested by the family.On 2/12/26 at 1:27 PM, during an interview, the Administrator reported he expected staff to honor resident privacy and not post personal care information in resident rooms.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by failing to identify and document the use of a lap belt as a restraint for one (1) of eighteen (18) sampled residents. Resident #55.Findings include:A review of the facility's Restraint Policy, undated, revealed, .Physical restraints are defined as any manual method or physical mechanical device, material, or equipment attached.to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.On 2/9/26 at 3:55 PM, during an observation, Resident #55 was observed with a soft belt secured across her lap while up in a wheelchair.On 2/10/26 at 11:46 AM, during an observation, Licensed Practical Nurse (LPN) #1 asked Resident #55 three (3) times to remove the belt. Resident #55 stared at the nurse and did not respond to the request.On 2/11/26 at 11:32 AM, during an interview, the Director of Nursing (DON) reported the facility failed to identify the resident's lap belt as a restraint. She reported the importance of properly identifying the belt as a restraint as a way to ensure staff were aware of required monitoring, including releasing it every thirty (30) minutes and checking for proper fit. She reported that the Quality Assurance (QA) nurse was responsible for ensuring restraints were identified properly and stated she would ensure proper assessment for restraint use and reduction.On 2/11/26 at 11:36 AM, during an interview, LPN #2, QA nurse, reported he did not identify Resident #55's lap belt as a restraint. He reported he was under the impression the resident could remove the belt and stated he would ensure residents were properly assessed for restraint use in the future.On 2/12/26 at 10:42 AM, during an interview, the Administrator reported Resident #55's lap belt should have been identified as a restraint. He reported the resident had previously been able to remove the belt, but her cognition had declined and she should have been evaluated more frequently. He reported his expectation was for the lap belt to be properly identified and monitored for continued need.A record review of Resident #55's Face Sheet revealed the facility admitted Resident #55 on 2/26/24 with diagnoses including Unspecified Dementia.A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/21/26 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident's cognition was severely impaired.A record review of Resident #55's medical record revealed there was no documentation identifying the use of a lap belt as a restraint.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and state board of nursing information review the facility failed to follow professional standards by permitting an unlicensed Certified Nursing Aide (CNA) to apply a medicated product, zinc oxide, during incontinent care for one (1) of three (3) residents observed for care. Resident #10.Findings include:A review of the Mississippi Board of Nursing website (www.msbn.ms.gov) revealed, Can a RN (Registered Nurse) delegate the administration of medicated ointments, lotions, and protective skin barriers to unlicensed personnel? .The registered nurse may .2. Assign duties of administration of patient medications to other licensed nurses only.On 2/11/26 at 12:35 PM, during an observation, CNA #2 provided catheter and incontinent care to Resident #10 and applied zinc oxide to the perineal folds.A record review of the Order Summary Report for Resident #10 revealed a Physician's Order, dated 2/2/26, for Zinc Oxide skin protection.CNA may apply per nurses' direction for skin protection only.On 2/11/26 at 12:45 PM, during an interview, Resident #10 reported staff routinely applied zinc oxide after catheter and incontinent care.On 2/11/26 at 12:50 PM, during an interview, CNA #2 reported she was instructed by the Director of Nursing (DON) to apply zinc oxide after incontinent episodes to prevent skin breakdown.On 2/12/26 at 2:00 PM, during an interview, the DON reported she instructed CNAs to apply zinc oxide to incontinent residents for skin protection and stated she was unaware zinc oxide was considered a medicated product.On 2/12/26 at 2:12 PM, during an interview, the Administrator reported he was unaware zinc oxide was considered a medicated product and stated he was seeking a non-medicated barrier cream alternative.A record review of the Face Sheet revealed the facility admitted Resident #10 on 11/25/25 with diagnoses including Heart Failure.A record review of Resident #10's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/26 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, record review, and facility policy review, the facility failed to act upon a pharmacist-identified medication irregularity related to crushing an extended-release medication for one (1) of three (3) residents reviewed for medication administration. Resident #8.Findings include:A review of the facility's Pharmacy Consultant Policy, undated, revealed, . It is the policy of this facility that a licensed pharmacist will provide consultation . A monthly report of any irregularities found is made to the resident's physician (placed on the medical record) The Director of Nursing (DON) . Action taken based on the report will be documented . A file of monthly reports will be maintained by the Director of Nursing .A record review of the Pharmacy Recommendations for Nursing for Resident #8, dated 11/12/25 revealed, . Medication Administration Alert: Crushing of Meds. This resident's record indicates that their meds are (or can be) crushed. The following meds SHOULD NOT be crushed, (change to another form of therapy): . Toprol XL (metoprolol succinate ER) - Extended Release - can not be crushed or chewed .A record review of the Order Summary Report with active orders as of 2/10/26 revealed Resident #8 had a Physician's Order, dated 12/15/25 for Toprol XL Oral Tablet Extended Release 24 Hour 50 mg (milligram) (Metoprolol Succinate) Give 1 tablet via PEG-Tube one time a day for Hypertension.A record review of Resident #8's Medication Administration Record (MAR) for November 2025 revealed Toprol XL Extended Release 50 mg was administered by mouth daily (start date 2/8/24). A record review of the December 2025 MAR revealed Toprol XL Extended Release 50 mg was administered daily via percutaneous endoscopic gastrostomy (PEG) tube beginning 12/16/25. A record review of the January and February 2026 MARs revealed the medication continued to be administered daily via PEG-Tube through 2/12/26.On 2/11/26 at 9:31 AM, during an observation and interview, Licensed Practical Nurse (LPN) #3 was observed preparing and administering medications to Resident #8 via PEG tube. LPN #3 crushed Toprol XL Extended Release 50 mg and administered the medication via PEG tube. LPN #3 reported she was not aware the medication should not be crushed.On 2/11/26 at 2:22 PM, during a phone interview, the Pharmacy Consultant reported Toprol XL Extended Release should not be crushed and explained crushing could result in altered absorption, decreased effectiveness, and release of the full dose at one time, increasing potential side effects. She reported she issued a nursing consult on 11/12/25 identifying medications that should not be crushed for Resident #8 and explained recommendations are sent to the Director of Nursing (DON) for follow-up and correction.On 2/11/26 at 3:00 PM, during an interview, the DON reported when pharmacist recommendations include medications that should not be crushed, she typically posts a list of medications that cannot be crushed but did not ensure the medication was changed to an appropriate formulation for PEG administration. She reported Resident #8 received the PEG tube in 12/2025 and medications should have been converted to an appropriate form.On 2/12/26 at 12:30 PM, during a follow-up interview, the DON reported it was her responsibility to follow through on pharmacist recommendations and ensure timely completion. She reported the recommendation for Resident #8 was missed and confirmed several months was not a timely response.On 2/12/26 at 12:59 PM, during an interview, the Nurse Practitioner reported Toprol XL Extended Release should not be crushed due to its extended-release formulation. She reported the medication should have been changed to an appropriate formulation after PEG placement and stated the issue was missed.On 2/12/26 at 1:27 PM, during an interview, the Administrator reported nursing staff were expected to follow through timely on pharmacist recommendations and correct identified irregularities.A record review of the Face Sheet revealed the facility admitted Resident #8 on 2/7/24 with diagnoses including Essential (Primary) Hypertension and Encounter for Attention to Gastrostomy.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed Resident #8 required a Staff Assessment for Mental Status indicating memory problems with short- and long-term memory. Section K revealed the resident had a feeding tube.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, record review, and facility policy review, the facility failed to ensure dietary staff demonstrated competency in sanitation procedures for the three-compartment sink for one (1) of three (3) kitchen observations.Findings include:A review of the facility's Manual Warewashing Policy, dated 10/17 revealed, .Food service pots and pans that cannot fit in the dish machine or cleaned and sanitized in a three-compartment sink.Procedure.5) Third Compartment Sink a) Fill the third sink with water and sanitizer to the correct concentration. Hot water can be used as an alternative. B) Immerse items in the third sink in hot water or chemical sanitizing solution. I)If hot water immersion is used, the water must be a minimum of 171 F and items must be immersed for 30 seconds. Ii) If chemical sanitizing is used, the sanitizer must be mixed to the proper concentration. Follow manufacturers' recommendations. The following are published guidelines. (1) Chlorine-Immerse for 7 seconds in water temperature 100 degrees F (Fahrenheit) (2) Iodine-Immerse for 30 seconds in water temperature 68 degrees F. (3) Quats-Immerse for 30 seconds in water temperature 75 degrees F. (6) The concentration of the sanitizing solution is checked with an appropriate test kit when the sink is filled and again if the solution is used for an extended period of time.On 2/10/26 at 10:48 AM, during an observation and interview, Dietary Aide (DA) #2 washed pots and pans in the three-compartment sink. Pots and pans were observed air drying on a table next to the sink. The third sink contained warm water, and a test strip did not register sanitizer concentration. DA #2 aide added sanitizing solution directly from the container into the sink without measuring the amount. After adding the solution, the test strip registered between 200 and 400 parts per million (PPM). DA #2 confirmed the sanitation equipment was not working and she added sanitizer based on estimation. During an interview at this time, the Dietary Manager (DM) stated she had washed pots and pans earlier using what she believed was correct sanitation and confirmed the sanitation tubing had been disconnected. The DM stated she did not know who disconnected the solution tubing.On 2/11/26 at 11:51 AM, during an interview, the Maintenance Director stated she contacted the sanitation vendor after being notified the sanitation equipment was not working.On 2/11/26 at 12:06 PM, during an interview, the Sanitation Vendor Representative stated the sanitation equipment was functioning properly and explained sanitizer should not be manually poured into sinks, as the equipment is designed to dispense the correct concentration, confirming staff were not utilizing the equipment as designed.On 2/12/26 at 11:28 AM, during an interview, the Administrator stated staff are expected to use sanitation equipment according to manufacturer guidelines.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to follow Enhanced Barrier Precaution (EBP) requirements by not wearing required personal protective equipment (PPE), specifically a gown, during percutaneous endoscopic gastrostomy (PEG) tube care for one (1) of five (5) residents observed for care. Resident #8.Findings include:A review of the facility's Enhanced Barrier Precautions Policy, dated 4/30/25, revealed, .Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms to residents .Policy Interpretation and Implementation EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply.Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include.device care or use.feeding tube.Communication -Staff are trained prior to caring for residents on EBP and annually with PPE (Personal Protective Equipment) in-service.An orange sign will be placed on the resident door frame and a green dot on the name tag next to the door indicating the need for EBP.On 2/11/26 at 10:14 AM, an observation of Resident #8's, Enhanced Barrier Precaution signage, including an orange sign and green dot, was observed on the resident's door. During the same observation, Licensed Practical Nurse (LPN) #4 performed PEG tube dressing care and did not wear a gown while providing the care.On 2/12/26 at 1:00 PM, during an interview with LPN #4, she confirmed she did not wear a gown during PEG tube care for Resident #8 and stated she forgot to put it on. She reported she had been trained to wear personal protective equipment (PPE) when providing care to residents with medical devices and Enhanced Barrier Precaution signage.On 2/12/26 at 1:03 PM, during an interview with Registered Nurse (RN) #1/Infection Preventionist, she stated staff are trained to wear PPE when caring for residents identified with Enhanced Barrier Precaution signage and medical devices.On 2/12/26 at 1:04 PM, during an interview with the Director of Nursing (DON), she stated she expects staff to follow Enhanced Barrier Precaution policies to prevent infection transmission.On 2/12/26 at 1:05 PM, during an interview with the Administrator, he stated he expects staff to follow infection control and Enhanced Barrier Precaution policies when providing resident care. A record review of training documentation from Long-Term Care Consultant, LLC, dated 8/03/25, revealed Licensed Practical Nurse (LPN) #4 received training on Enhanced Barrier Precautions.A record review of the Face Sheet revealed the facility admitted Resident #8 on 2/7/24 with diagnoses including Essential (Primary) Hypertension and Encounter for Attention to Gastrostomy.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/25 revealed Resident #8 required a Staff Assessment for Mental Status indicating memory problems with short- and long-term memory. Section K revealed the resident had a feeding tube.A record review of the Order Summary Report with active orders as of 2/10/26 revealed Resident #8 had a Physician's Order, dated 12/15/25 for NPO (nothing by mouth) status and included PEG care orders.