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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	**11 PECAN DRIVE , COLUMBIA, Mississippi, 39429**

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #2807839 and CI MS #2974450), at the facility, on 4/20/26. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #2807839 and CI MS #2974450 were Facility Reported Incidents (FRIs) regarding accidents/falls and F656 and F689 was cited as a result of both CIs. The facility was licensed for 86 beds and had a census of 83 residents.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656		

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 reverse for further 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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F0656 SS = D	Continued from page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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 #1 A 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…".	F0656		

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F0656 SS = D	Continued from page 2 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 #2 Record 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 10/24/24 A 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	F0656		

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F0656 SS = D	Continued from page 3 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 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.	F0656		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689		

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F0689 SS = D	Continued from page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 #1 A 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	F0689		

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F0689 SS = D	Continued from page 5 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 #2 A 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	F0689		

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F0689 SS = D	Continued from page 6 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.	F0689		