Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #2807839 and CI MS #2974450 were Facility Reported Incidents (FRIs) regarding accidents/falls and M640 was cited as a result of both CIs.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE 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	M0640		

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

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M0640	Continued from page 1 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 #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…"	M0640		

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M0640	Continued from page 2 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.	M0640		