MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 1/8/23 to 1/11/23. During the survey, the SA determined the facility was not in compliance with the Mississippi regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M500.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance	M 500		2/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 500	Continued From page 1 with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 500	Continued From page 2 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 500	Continued From page 3 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure resident rights were honored by prohibiting residents from group activities and restricting resident use of common areas of the facility without clinical justification for three (3) of 18 sampled residents, with the potential to affect 62 residents. Residents # 3, #4, and #45	M 500	1. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice: A. On 1/8/23 the Director of Nurses (DON) spoke with all staff who were working on the affected wing and informed them that only COVID-19 positive residents had to quarantine in their rooms, everyone else on the wing could come	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 500	Continued From page 4 Findings include: Record review of the facility's policy, "Resident Rights Policy," updated 9/5/15, revealed, "It is the policy of this facility that resident rights will be addressed as follows: ...Exercise rights ...Each resident will be able to exercise his/her rights as follows: As a resident in this facility... 2. To voice grievances to: ...State Department of Health ..." Resident #3 On 1/08/23 at 11:25 AM, during an observation and interview with Resident #3, he was dressed and sitting in his room with the door open. Resident #3 revealed that because his unit of the facility has COVID-19 positive residents, the facility has prohibited the COVID-19 negative residents from having group activities by restricting the use of common areas. A record review of the "Face Sheet" of Resident #3 revealed the resident was admitted by the facility on 5/27/22 with diagnoses including Rheumatoid Arthritis, Heart Disease, and Type 2 Diabetes Mellitus. A record review of Resident #3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/22, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Resident #4 On 1/08/23 at 11:45 AM, during an interview with Resident #4, the State Agency (SA) observed Resident #4 dressed and sitting in her room. She confirmed that since her unit has COVID-19-positive residents, the facility has restricted the COVID-19 negative residents from entering the common areas in the facility.	M 500	and go as they please within the facility. B. On 1/8/23 the DON also met with each resident who was COVID-19 negative and informed them that they did in fact have the right to come out of their room and go to activities, the dining room, lobby area, etc. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A. The facility has identified that any resident with a roommate that has tested positive for COVID-19 and/or resides on a wing where residents are being quarantined for COVID-19 have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A. On 1/9/23 the DON began doing an in-service with staff members across all departments concerning the importance of observing the rights of residents who do not require quarantining due to a contagious illness. She completed in-servicing all staff members on 1/13/23. B. On 1/24/23 the Administrator amended the policy titled "Covid-19 Outbreak Plan" to include specific language on how to treat a negative roommate of a COVID-19 positive resident as well as any negative resident that resides on the same wing as a COVID-19 positive resident. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A. On 1/13/23, the interdisciplinary team (IDT) added to its daily meetings a time to discuss any resident who may have tested	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 500	Continued From page 5 A record review of the "Face Sheet" revealed the facility admitted Resident #4 on 3/22/19, with diagnoses including, Acute kidney Failure, Type 2 Diabetes Mellitus, and Heart Failure. A record review of Resident #4's Quarterly MDS with an ARD of 11/21/22, revealed a BIMS score of 15, which indicated she was cognitively intact. Resident #45 On 1/08/23 at 11:55 AM, during an interview with Resident #45, she revealed that the facility has required that she remain on her unit and not enter the common areas in the facility, because there are COVID-19 positive residents on her hall. A record review of the "Face Sheet" revealed the facility admitted Resident #45 on 11/19/17 with diagnoses including Essential hypertension, Chronic Kidney Disease, and Type 2 Diabetes Mellitus. A record review of Resident #45's Quarterly MDS with an ARD of 10/10/22, revealed she had a BIMS score of 15, which indicated she was cognitively intact. On 1/08/23 at 12:05 PM, an interview with Certified Nurse Assistant (CNA) #1, working on the south unit of the facility, confirmed the facility had restricted both COVID-19 positive and negative residents from exiting the unit and going to any common areas in the facility. On 1/09/23 at 9:25 AM, during an interview with License Practical Nurse (LPN) #1 confirmed the south unit has several residents that are COVID-19-positive. LPN #1 revealed she was informed by the Director of Nursing (DON) and	M 500	positive for COVID-19. During these meetings we will ensure that the team knows that every other resident who is not positive for COVID-19 has the right to move about freely in the facility. This will be ongoing. B. Beginning 1/13/23, the Social Worker will follow up with any negative roommate of a COVID-19 positive resident as well as any negative resident that resides on the same wing as a COVID-19 positive resident to ensure that they know they are able to come out of their room whenever they want to. We will end this practice once we are out of outbreak status and resume when we are back in outbreak status. C. Beginning 1/13/23, the Activities Director will also monitor any negative roommate of a COVID-19 positive resident as well as any negative resident that resides on the same wing as a COVID-19 positive resident for any change in their normal routine, to ensure they know they may continue coming out of their room and attend activities. We will end this practice once we are out of outbreak status and resume when we are back in outbreak status. D. This plan of correction will be brought before the Quality Assurance & Performance Improvement Council on 2/3/2023 and integrated into our Quality Assurance system at this time. 5. Indicate the date the corrective actions will be completed: A. These actions will be completed on 2/3/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PH10	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE	11 PECAN DRIVE COLUMBIA, MS 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) COMPLETE DATE
M 500	Continued From page 6 Infection Preventionist (IP) that the residents that are COVID-19 negative, as well as the COVID-19 positive residents were to remain on the unit and not allowed to exit to common areas in the facility. On 1/09/23 at 12:15 PM, an interview with the IP confirmed there were both COVID-19-positive and negative residents on the south unit. The IP revealed to keep COVID-19 from spreading throughout the facility, she felt it would be best to prevent the negative residents on that unit from entering the common areas. On 1/09/23 at 12:25 PM, an interview with the DON revealed she had requested the residents in the south unit, who are COVID-19 negative to remain within the unit, to avoid the spread of COVID-19 to other areas of the facility. The DON confirmed she informed her staff that COVID-19 negative residents should avoid the common areas within the facility. On 1/09/23 at 12:30 PM, an interview with the Administrator revealed his expectation is that COVID-19 negative residents are allowed to enter the common areas in the facility.	M 500		