

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Glen Oaks Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Susanne Street Lucedale, MS 39452	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide the resident representative with written notice containing the required transfer information when the resident was transferred to the hospital with return anticipated for one (1) of two (2) residents reviewed for hospitalization. (Resident #38).Findings include:A review of the facility's policy, Transfer or Discharge Notice revised November 2023, revealed, .Policy Interpretation and Implementation.5. The resident and representative will be notified in writing of the following information. a. The specific reason for the transfer or discharge. f. The effective date of the transfer. g. The location to which the resident is being transferred or discharged .A record review of the facility's admission Record revealed the facility admitted Resident #38 on 06/15/2026 with diagnoses including Respiratory Failure, Unspecified with Hypoxia.A record review of the Discharge Return Anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/14/26 revealed Resident #38 was discharged to a short-term general hospital with return anticipated.A record review of the admission MDS with an ARD of 06/22/2026 revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.A record review of the Order Details revealed a physician order dated 07/14/26 for D/C (discharge) to (proper name of local hospital).A record review of Resident #38's medical record failed to identify documentation that the resident representative received the required written transfer notice containing the reason for the transfer, the effective date of the transfer, and the location to which the resident was transferred on 7/14/26.On 07/29/26 at 2:11 PM, during an interview, the Business Office Manager (BOM) acknowledged she did not provide the resident representative with a written transfer notice when Resident #38 was transferred to the hospital on [DATE]. The BOM explained she believed the resident was being discharged rather than transferred with return anticipated. The BOM stated she would verify a resident's discharge status before issuing future transfer notifications.On 07/29/26 at 2:16 PM, during an interview, the Administrator acknowledged the resident representative did not receive a written transfer notice for Resident #38's hospitalization on 07/14/26. The Administrator confirmed the facility expected written transfer notifications to be provided to the resident representative each time a resident was transferred to the hospital.		

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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy review, the facility failed to develop and implement comprehensive person-centered care plans, as evidenced by failing to develop a comprehensive care plan for a resident with an active urinary tract infection (UTI) (Resident #27) and failing to implement an existing comprehensive care plan for oxygen therapy (Resident #28) for two (2) of (12) residents reviewed for comprehensive care planning. Findings include: A review of the facility's policy titled, Using the Care Plan revealed, The care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have the responsibility for providing care to the resident. Resident #27 A record review of the admission Record revealed the facility initially admitted Resident #27 on 10/21/2015 and she was readmitted on [DATE]. She had diagnoses including Type 2 Diabetes Mellitus and UTI. A record review of the Patient Visit Information revealed Resident #27 was evaluated at a local hospital on [DATE] and received patient instructions for Female Urinary Tract Infection with a prescription for Cephalexin 500 milligrams (mg) four (4) times daily. A record review of the Order Summary Report revealed Resident #27 had a Physician's Order, dated 7/23/26, for Cephalexin 500 mg four times daily for ten (10) days. A review of the comprehensive care plan for Resident #27 revealed there was no designated care plan with interventions related to the new diagnoses of UTI. On 07/29/2026 at 2:35 PM, in an interview with Registered Nurse (RN) #1, she explained that the floor nurses are responsible for inputting care plans for new physician orders. She reported Medical Records reviews the physician orders daily and makes sure the physician orders are added as an intervention, but it was ultimately her responsibility to make sure care plans are developed. RN #1 confirmed that Resident #27 returned from the hospital on 7/22/26 and had orders for antibiotics and a diagnosis of UTI. She also confirmed there was no care plan developed with a problem or focus of UTI. She explained that she expected a comprehensive care plan to be developed for a new diagnosis, which would include a focus, goal, and interventions. On 07/29/2026 at 3:10 PM, in an interview with the Director of Nursing (DON), he stated he expected a care plan to be developed for residents with new diagnoses to include interventions for staff to follow to take care of residents. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28 A record review of the Care Plan Report for Resident #28 revealed interventions included Oxygen at 3 L (liters) per NC (nasal cannula) to maintain O2 (oxygen) > (greater than) 92%. Obtain O2 sat every shift with a start date of 2/25/2026. On 07/28/26 at 3:39 PM, during an observation, Resident #28 was receiving oxygen via nasal cannula at (2) liters per minute. On 07/29/26 at 2:50 PM, during an observation, Resident #28 continued to receive oxygen via nasal cannula at two (2) liters per minute. On 07/29/26 at 2:54 PM, during an interview, Licensed Practical Nurse (LPN) #1 confirmed Resident #28 was receiving oxygen at (2) liters per minute. LPN #1 reviewed the physician order and confirmed the prescribed oxygen flow rate was three (3) liters per minute. LPN #1 acknowledged there was no physician order authorizing the lower oxygen flow rate and could not explain the discrepancy. On 07/29/26 at 2:55 PM, during an interview, Registered Nurse (RN) #1 confirmed the purpose of the comprehensive care plan was to guide staff in providing resident care. RN #1 confirmed staff were expected to implement the interventions contained in the comprehensive care plan. On 07/30/26 at 1:01 PM, during an interview, the Administrator confirmed staff were expected to verify oxygen flow rates, follow physician orders, notify the physician of discrepancies, monitor residents receiving oxygen therapy, and implement the resident's comprehensive care plan. A record review of the admission Record revealed the facility admitted Resident #28 on 02/25/26 with diagnoses including Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. A record review of the Order Summary Report for Resident #28 revealed orders for oxygen at (3) liters per minute via nasal cannula, dated 3/9/26. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/2/2026 for Resident #28 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating thre resident was cognitively intact.		

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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 facility policy review, the facility failed to provide care and services in accordance with physician orders by administering oxygen at a flow rate different from the physician-ordered oxygen therapy for one (1) of (1) resident reviewed for oxygen therapy. (Resident #28). Findings include: A review of the facility's policy titled, Oxygen Administration revised October 2010, revealed .The purpose of this procedure is to provide guidelines for safe oxygen administration. review physician orders. for oxygen administration. A review of the facility's policy titled, Conformity with laws and Professional Standards revised April 2007, revealed Our facility operates and provides services in compliance with. professional standards of practice that apply to our facility and types of services provided. During an observation on 07/28/26 at 3:39 PM, Resident #28 was receiving oxygen via nasal cannula at two (2) liters per minute. During an observation, on 07/29/26 at 2:50 PM, Resident #28 continued to receive oxygen via nasal cannula at (2) liters per minute. During an interview on 07/29/26 at 2:54 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #28 was receiving oxygen at (2) liters per minute. LPN #1 reviewed the physician order and confirmed the prescribed oxygen flow rate was three (3) liters per minute. LPN #1 acknowledged there was no physician order authorizing the lower oxygen flow rate and could not explain the discrepancy. During an interview on 07/30/26 at 1:01 PM, the Administrator confirmed staff were expected to verify oxygen flow rates, follow physician orders, notify the physician of discrepancies, and monitor residents receiving oxygen therapy. A record review of Resident #28's Medication Administration Record (MAR) for July 2026 revealed staff documented oxygen was administered at three (3) liters per minute on 07/28/26 and 07/29/26, the same dates Resident #28 was observed receiving oxygen at (2) liters per minute. A record review of the admission Record revealed the facility admitted Resident #28 on 02/25/26 with diagnoses including Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. A record review of the Order Summary Report for Resident #28 revealed a physician order dated 03/09/26 for oxygen at three (3) liters per minute via nasal cannula. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/2/2026 for Resident #28 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on staff interview, record review, and facility policy review the facility failed to comply with state nursing facility staffing requirements by failing to designate a charge nurse responsible for supervision of the total nursing activities in the facility during the hours of 3:00 PM to 11:00 PM shift, separate from the medication/treatment nurse assignment for three (3) of (3) shifts reviewed for charge nurse supervision. Findings include: A review of the facility's policy titled, Staffing, revised April 2007, revealed, .Policy Interpretation and Implementation 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. A record review of the Staff Reporting Form revealed there was not a designated charge nurse assigned for the 3:00 PM to 11:00 PM shift on 07/28/26, 07/29/26, or 07/30/26. A record review of the Minimum Standards for Institutions for the Aged or Infirm for Rule 45.4.1 Nursing Facility, revealed, .To be classified as a facility, the institution shall comply with the following staffing requirements. 2. Each facility shall have the following licensed personnel as a minimum. D. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. On 07/29/26 at 3:22 PM, during an interview, the Director of Nursing (DON) stated he served as the charge nurse from 7:00 AM until approximately 4:30 PM on some days. The DON explained that after 4:30 PM, the medication/treatment nurses also served as the charge nurses. The DON acknowledged the facility did not designate a separate charge nurse from the medication/treatment nurse role. The DON further acknowledged he was unaware the Minimum Standards for Institutions for the Aged or Infirm required a designated charge nurse separate from the medication/treatment nurse assignment for the 3:00 PM through 11:00 PM shift. On 07/29/26 at 3:30 PM, during an interview, the Administrator confirmed the medication/treatment nurses also served as the charge nurses during the 3:00 PM to 11:00 PM shift. The Administrator acknowledged the purpose of a separate charge nurse was to provide supervision of nursing services while allowing the medication/treatment nurse to focus on medication administration and treatments.		