STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255206	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Health and Rehabilitation	310 Emerald Drive Columbus, MS 39702

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 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 record review, staff interview and facility policy review, the facility failed to ensure residents were treated with respect and dignity when a staff member spoke rudely and in a disrespectful manner to one (1) of three (3) residents reviewed. Resident #2 Findings included:Record review of the facility policy titled, Resident Rights, revealed Standard, Employees shall treat all residents with kindness, respect and dignity .Record review of Grievance/Concern/Comment Report dated 1/29/26, revealed that Resident #2's family reported that Certified Nursing Assistant (CNA) #1 talked down to the resident and overheard CNA #1 state to the resident I told you that I was coming back to change you!An interview with the Social Services Director (SSD) on 5/20/26 at 8:35 AM, he stated he made a follow-up call to check on the resident after discharge and received report from the family that CNA #1 had talked down to the resident on the day of discharge. He stated he immediately reported the incident to the Director of Nursing (DON).An interview with the Administrator on 5/20/26 at 8:40 AM, she verified that the facility investigated the report and found that CNA #1 did not provide good customer service to Resident #2. The Administrator further verified that this meant that the CNA did not treat the resident with dignity and respect. She agreed that the resident should have been treated with dignity and respect.Record review of the admission Record revealed the facility admitted Resident #2 on 10/10/25 with diagnosis that included Acute Respiratory Failure and discharged the resident home on 1/18/26.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on staff interview, record review, and facility policy review the facility failed to ensure a resident was provided education and sufficient information regarding advance directives and the implications of assigning a Power of Attorney (POA) prior to obtaining the resident's agreement for one (1) of three (3) residents reviewed for advanced directives. Resident #1Findings Included:Record review of the facility policy titled, OBRA (Omnibus Budget Reconciliation Act) Resident Self-determination Checklist revealed, Policy.Every resident has the right to give informed consent before diagnosis or treatment. Advance Directives provide residents the ability to legally decide about their future medical treatment .Record review of Advance Health Care Directive, revealed the form was signed with Resident #1's name and notarized by the facility's Human Resources personnel on 2/19/26 making Resident #1's mother his health care agent.Record review of the admission Record revealed the facility admitted Resident #1 on 2/10/26 with diagnoses that included Aphasia follow Cerebral Infarction and Cognitive Communication Deficit. The admission Record listed Resident #1's spouse as his Responsible Party (RP).An interview on 5/20/26 at 10:08 AM, with Human Resources (HR) verified that she was a Notary Public. She stated that on 2/19/26 she was called to the business office and introduced to Resident #1's mother. The mother asked her to come to the room and notarize paperwork. She explained that Resident #1's mother stated that they had an Advance Directive (AD) for Resident #1 that an alternative facility required in order to transfer him to that facility. HR stated that she asked Resident #1 if it was ok for his mother to sign his name and he indicated that it was. She stated that she verified the mother's identification and then notarized the paperwork. HR verified that she did not know who the Resident's RP was because she did not check his medical record to determine who was listed. She further stated that Resident #1 was not provided any explanation or education of the details of the Advance Health Care Directive. She then added that the resident's ability to communicate waxed and waned throughout his stay indicating that the facility was unsure of his cognitive status. HR agreed that residents should receive education in order to make informed consent, she should have checked the chart to see who the RP was, and that she should not have notarized the Advance Health Care Directive.An interview with the Administrator on 5/20/26 at 12:46 PM she stated that facility staff are not to notarize any forms for residents and/or visitors and it was her expectation that HR would not have notarized the form.Record review of Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 2/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating that the resident was severely cognitively impaired.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and facility policy review the facility failed to ensure medications were stored in a safe and secure manner by leaving one (1) of eight (8) medication carts unlocked and unattended. Findings included:Record review of the facility policy, titled Medication Storage revealed Policy Explanation and Compliance Guidelines, 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts.).An observation on 5/19/26 at 3:30 PM, revealed a medication cart located midway down the hall that was unlocked. Licensed Practical Nurse (LPN) #1 was noted to be down the hall away from the unlocked cart.An interview with LPN #1 on 5/19/26 at 3:36 PM, he verified that it was his medication cart and he did leave the cart unlocked. He agreed that he should have locked the cart before he walked away from it. He verified that leaving the cart unlocked and unattended could allow resident access to medications that could cause harm.An interview with the Administrator on 05/19/26 at 7:00 PM, she stated that it was her expectation that LPN #1 would have locked the cart before walking away.