STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255261	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks Rehabilitation and Healthcare Center	3716 Highway 39 North Meridian, MS 39301

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, record review, facility investigation and facility policy review, the facility failed to implement its abuse prevention policy when Licensed Practical Nurse (LPN) #2 did not immediately notify the Administrator or designee of an abuse allegation for one (1) of 3 sampled residents, Resident #1.Findings Include: A review of the facility's policy, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated 10/14/2025, revealed, .It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment.are reported immediately to the Administrator of the facility.Compliance Guidelines.8Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation.When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated 1. The Licensed Nurse will.c. Notify the Administrator or designee. A record review of the facility's Verification of Investigation revealed the DateTime of Occurance was 08/06/2025 at 12:20 PM and was completed by the facility's Administrator for Resident #1. Review of the .initial and final report revealed on 8/6/25 at 12:20 PM, Resident #1 reported to Licensed Practical Nurse (LPN) #1 that a girl last night told me not to touch my call bell again or she was going to put something on me. LPN #1 then reported this immediately to the Director of Nursing (DON) in which he repeated the allegation. Resident #1 stated it was a CNA, but was unable to recall the CNA's name. The resident's roommate identified the CNA as CNA #1. The DON contacted LPN #2 who had worked on 8/5/25 and she reported that while she was passing medicines, she overhead Resident #1 cursing in his room. Resident #1 told LPN #2 that the CNA had told him not to touch his call bell or she was going to spank him. LPN #2 then called CNA #1 into the room and the CNA explained she was joking and apologized to the resident and he responded It's fine, I'm done with it. Corrective actions included a full body audit was completed on Resident #1, interviews were conducted with all alert and oriented residents to identify any complaints regarding abuse/neglect. Body audits were completed on residents that were unable to be interviewed. All employees were educated on abuse/neglect, reporting requirements, and professional conduct/communication. On 11/19/25 at 9:56 AM, during an interview with CNA #1, she stated that on 8/5/25, she had food trays in her hand when she saw Resident #1's call light on. CNA #1 entered the room and asked the resident if he needed anything. She stated she asked Resident #1 to turn off the call light, and he told her he did not turn it on. CNA #1 reported she said, I know baby, I know you didn't, I asked if you can turn it off. I'm going to spank you, I asked if you can turn it off for me. CNA #1 stated the resident laughed and turned off the light. Later, she was informed that her comment offended the resident. CNA #1 stated she apologized to Resident #1, was suspended pending investigation, and received in-service training on professional communication. On 11/19/25 at 10:49 AM, during an interview with LPN #1, she stated that on 8/6/25, Resident #1 reported that during the previous night's shift on 8/5/25, CNA #1 had told him that if he used his call light, she would put something on him. LPN #1 reported the allegation immediately to the DON, who then initiated the facility's investigation. LPN #1 confirmed that CNA #1 was suspended and that all staff were in-serviced on reporting abuse and professional communication.On 11/19/25 at 11:23 AM, during an interview with LPN #2, she stated that on 8/5/25, she heard Resident #1 cursing in his room. LPN #2 stated she entered to check on the resident, who told her that a CNA had said if he touched his call (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255261	A. Building B. Wing	11/19/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light again, she would get him. LPN #2 called CNA #1 into the room to discuss the incident. CNA #1 admitted to saying it jokingly and apologized. LPN #2 stated she did not report the allegation because the resident said he was fine. LPN #2 confirmed she did not notify the Administrator or DON and was later suspended during the investigation. LPN #2 acknowledged she knew she should have safeguarded the resident and immediately notified the Administrator or DON.On 11/19/25 at 11:50 AM, during an interview with the DON, she stated she was not informed of the incident until 8/6/25. The DON reported that LPN #2 did not report it immediately because she thought the resident knew the CNA was joking. The DON confirmed that LPN #2 was suspended and received one-on-one in-service training on reporting and professional communication. The DON stated it was her expectation that staff contact her day or night if they hear or suspect any form of abuse. On 11/19/25 at 2:06 PM, during an interview with the Regional Director of Clinical Services (RDCS), she stated that she was notified of the incident by the DON on 8/6/25. The RDCS confirmed that the failure to report the allegation timely was identified, and corrective action was taken through suspension and re-education. The RDCS stated her expectation was that all staff report even the suspicion of abuse immediately to the DON or Administrator. A record review of the admission Record revealed the facility admitted Resident #1 on 9/25/19 with current diagnoses including Abnormalities of Gait and Mobility.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/27/2025 revealed Resident #1had a Brief Interview for Mental Status (BIMS) score of 13 indicating he was cognitively intact.Based on the facility's implementation of corrective Actions on 8/7/25, the SA determined the deficiency to be Past Non-Compliance (PNC) and corrected as of 8/7/25, prior to the SA's entrance 11/19/25.Validation:The SA validated on 11/19/25 through interview and record review, that all corrective actions had been implemented as of 8/7/25 and the facility was in compliance, prior to the SA's entrance on 11/19/25.