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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, record review, and facility policy review, the facility failed to revise the comprehensive care plan to reflect actual falls with interventions for one (1) of four (4) sampled residents. Resident #1.Findings include:A review of the facility's policy, Comprehensive Care Plans, dated 11/14/25, revealed, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.to meet a resident's medical, nursing.needs.A record review of the Care Plan Report revealed Resident #1 had a Focus including at risk for falls r/t (related to) confusion. The care plan was not revised to include the two (2) actual falls, along with interventions, that occurred on 3/27/26. The care plan also had an intervention dated 4/1/24 for Bed in low position.A record review of the Nursing Progress Note, dated 3/27/26 at 7:22 AM, for Resident #1 revealed, .Nurse called to room at 0710 (7:10 AM). Found resident on floor.Called (proper name of ambulance service).Will notify AM (morning) nurse.A record review of the ED (Emergency Department) information for Resident #1 from a local acute care hospital, dated 3/27/26 at 8:06 AM, revealed, .Chief Complaint Patient presents with Fall.NH (Nursing Home) staff reports that she was found on the floor this morning.A review of the clinical record for Resident #1 revealed there was no facility fall investigation completed for the fall that occurred on 3/27/26 at 7:10 AM.A record review of the Nursing Progress Note, dated 3/27/26 at 2:59 PM, for Resident #1 revealed, .Called to resident's room. Resident was noted lying on floor on right side.Resident remained on floor until (Proper Name of Ambulance Service) arrived.RP (Responsible Party) called and made aware. Requested to send to (Proper Name of Another Local Acute Care Hospital).A record review of the Emergency Department information for Resident #1 from another local acute care hospital, revealed, .arrival 3/27/26 14:36 (2:36 PM).Chief complaint Fall.EMS (emergency medical services) reports that patient was picked up from (first local acute care hospital ED) and taken back to nursing home. EMS reports shortly after, nursing home called with a reports that patient was found on the floor.A record review of the facility's Fall investigation for Resident #1, dated 3/27/26 at 1:45 PM, revealed .Incident Description.Nursing Description: Resident noted on the floor face down, in between bed and end table. The report was prepared by Registered Nurse (RN) #1.During an interview on 5/6/26 at 12:23 PM, Certified Nurse Aide (CNA) #2 she stated that when she had just arrived to work on the morning of 3/27/26 around 7:00 AM, Resident #1 was sent to the emergency room (ER). She stated when the resident returned from the hospital that afternoon, she had another fall within minutes. During an interview on 5/6/26 at 12:48 PM, Registered Nurse (RN) #1 explained Resident #1 had already been sent to the hospital for the first fall that occurred on 3/27/26 when she came on duty that morning. When Resident #1 returned to the facility by ambulance that afternoon, she entered the room with the EMT staff to assess the resident. She stated she left the room briefly to obtain vital sign equipment, and when she returned, Resident #1 was on the floor. RN #1 explained interventions put in place following the fall included keeping the bed in a low position and therapy services, although the intervention of Bed in low position was previously recorded on the care plan on 4/1/24 and was not a new intervention and therapy services was not listed as an intervention.During an interview on 5/7/26 at 1:02 PM, RN #2 stated she was the Minimum Data Set (MDS)/Care Plan nurse for the facility. She stated the purpose (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the care plan is to inform staff on how to care for residents by reviewing the care plan and ensuring the resident needs are met. During an interview, on 5/7/26 at 2:50 PM, the Director of Nursing (DON), stated the facility will educate staff regarding care plans and Kardex usage and will review care plan interventions for the safety of the residents. A record review of the admission Record for Resident #1 revealed the facility admitted Resident #1 on 3/8/25 and she had current diagnoses including of Metabolic Encephalopathy.A record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated her cognition was severely impaired.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and facility policy review, the facility failed to ensure the environment remained as free of accident hazards as possible as evidenced by failure to investigate an initial fall, implement interventions to prevent recurrence, and ensure the resident's bed was maintained in a low position for one (1) of four (4) residents reviewed for accidents. Resident #1 Findings include:A review of the facility's policy, Fall Prevention Program, dated 11/7/25, revealed .Each resident will.receive care services in accordance with their individual level of risk to minimize the likelihood of falls.Policy Explanation and Compliance Guidelines.9. When any resident experiences a fall, the facility will.d. Complete an incident report.A record review of the Nursing Progress Note, dated 3/27/26 at 7:22 AM, for Resident #1 revealed, .Nurse called to room at 0710 (7:10 AM). Found resident on floor.Called (proper name of ambulance service).Will notify AM (morning) nurse.A record review of the ED (Emergency Department) information for Resident #1 from a local acute care hospital, dated 3/27/26 at 8:06 AM, revealed, .Chief Complaint Patient presents with Fall.NH (Nursing Home) staff reports that she was found on the floor this morning.A review of the clinical record for Resident #1 revealed there was no facility fall investigation completed for the fall that occurred on 3/27/26 at 7:10 AM.A record review of the Nursing Progress Note, dated 3/27/26 at 2:59 PM, for Resident #1 revealed, .Called to resident's room. Resident was noted lying on floor on right side.Resident remained on floor until (Proper Name of Ambulance Service) arrived.RP (Responsible Party) called and made aware. Requested to send to (Proper Name of Another Local Acute Care Hospital).A record review of the Emergency Department information for Resident #1 from another local acute care hospital, revealed, .arrival 3/27/26 14:36 (2:36 PM).Chief complaint Fall.EMS (emergency medical services) reports that patient was picked up from (first local acute care hospital ED) and taken back to nursing home. EMS reports shortly after, nursing home called with a reports that patient was found on the floor.A record review of the facility's Fall investigation for Resident #1, dated 3/27/26 at 1:45 PM, revealed .Incident Description.Nursing Description: Resident noted on the floor face down, in between bed and end table. The report was prepared by Registered Nurse (RN) #1.On 5/6/26 at 9:45 AM, during an interview with Emergency Medical Technician (EMT) Student #1, he stated he and the EMT transported Resident #1 on 3/27/26 after a fall at the facility. He reported the resident had also been transported to a hospital earlier the same day and was returned to the facility. He reported Emergency Medical Services (EMS) had left the facility and were called back within minutes due to Resident #1 having another fall. He stated he did not believe the resident could have flipped over the bedrails. He reported Resident #1 was placed in bed with the bedrails raised and the head of the bed elevated prior to EMS departure on 3/27/26.On 5/6/26 at 11:49 AM, during an observation of Resident #1, she was in her room, which was across from the nurses' station. Quarter length bedrails were present on the bed on each side and the bed was in the lowest position. Resident #1 was unable to recall the fall event.On 5/6/26 at 12:23 PM, in an interview with Certified Nurse Aide (CNA) #2, she stated that when she had just arrived to work on the morning of 3/27/26 around 7:00 AM, Resident #1 was sent to the emergency room (ER). She stated when the resident returned from the hospital that afternoon, she had another fall within minutes. She stated the EMS personnel commonly leave resident beds elevated in a high position after returning residents to the facility.On 5/6/26 at 12:48 PM, during an interview with Registered Nurse (RN) #1, she explained Resident #1 had already been sent to the hospital for the first fall that occurred on 3/27/26 when she came on duty that morning. When Resident #1 returned to the facility by ambulance that afternoon, she entered the room with the EMT staff to assess the resident. She stated she left the room briefly to obtain vital sign equipment, and when she returned, Resident #1 was on the floor. She confirmed the bed was elevated. She stated Resident #1 had a raised area on her right forehead. RN #1 explained interventions put in place following the fall included keeping the bed in a low position and therapy (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services. She stated she did not complete a fall investigation report for the first fall for Resident #1 that occurred on 3/27/26 prior to her arrival to work.On 5/7/26 at 2:50 PM, in an interview with the Director of Nursing (DON), she stated the facility will implement a fall risk prevention program per facility policy and will implement fall interventions for the safety of the residents.A record review of the admission Record for Resident #1 revealed the facility admitted Resident #1 on 3/8/25 and she had current diagnoses including of Metabolic Encephalopathy.A record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated her cognition was severely impaired.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure bed rails were assessed for clinical indication, safety, and resident need and failed to obtain informed consent for bed rail use for one (1) of four (4) sampled residents. Resident #1Findings Include:A review of the facility's policy Proper Use of Bed Rails, dated 11/7/25, revealed, .It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails.Resident Assessment.2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails.On 5/6/26 at 11:49 AM, in an observation, Resident #1 was sitting in a wheelchair in her room. She had quarter-length bedrails on both sides of the bed that were raised.Record review of Resident #1's clinical record revealed there were no bed rail assessments and no informed consent records for bed rail use. On 5/7/26 at 2:20 PM, in an interview with the Director of Nursing (DON), she confirmed there was no bedrail assessment or informed consent records related to bedrail use. She stated the facility had recent system updates with the electronic health records and the informed consent may have been misplaced in medical records. A record review of the admission Record for Resident #1 revealed the facility admitted Resident #1 on 3/8/25 and she had current diagnoses including of Metabolic Encephalopathy.A record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated her cognition was severely impaired.