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	06/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and facility policy review, the facility failed to provide reasonable accommodation of needs by not individualizing a blind resident's call system for one (1) of nineteen (19) sampled residents (Resident #17). Findings included: A record review of the facility's policy, Policies and Procedures .Resident Rights, with a revision date of 11/30/2014, revealed, Policy: The facility will ensure that the resident is not deprived of his/her rights . On 06/23/2025 at 11:30 AM, during an interview with Resident #17, who is in a private room, she explained that she is blind and unable to see or reach the current call light system. She reported that even when the call light is within reach, she has no way of knowing whether it is functioning correctly. The resident expressed uncertainty and vulnerability when needing assistance and stated she often yells out for help. On 06/23/2025 at 11:41 AM, during an interview Certified Nursing Assistant (CNA) #3, explained that she occasionally provides care for Resident #17 and confirmed that the call light was attached to the wall rather than the resident's chair. She acknowledged the resident could not access the call light based on current setup. On 06/24/2025 at 7:42 AM, during an observation, Resident #17 was sitting up in bed. The call light was attached to the wall at the foot of the bed, out of the resident's reach. Resident #17 stated that no staff placed the call light within reach during the night and that staff never do so. When asked how she calls for assistance, she stated she has to yell out. On 06/26/2025 at 7:10 AM, during an interview with Licensed Practical Nurse (LPN) #2, who works the 11:00 PM to 7:00 AM shift, she accompanied the State Agency to the resident's room and confirmed that the call light was out of reach on the wall. She explained that the call light should not be placed at the foot of the bed, especially since the resident is blind and unable to see or reach it. On 06/26/2025 at 7:25 AM, during an interview with the Director of Nursing (DON) in Resident #17's room, she stated it would be beneficial to obtain a more accessible device for residents needing assistance, especially for those with vision impairments. A record review of Resident #17's admission Record revealed an admission date of 08/09/2024, with diagnoses including Legal Blindness and Anxiety Disorder. (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	06/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/19/2025 revealed a Brief Interview for Mental Status (BIMS) score of thirteen (13), indicating Resident #17 was cognitively intact.

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	06/26/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure ongoing assessment and documentation of skin integrity for one (1) of two (2) residents reviewed for wound care. Specifically, Resident #35, who was at high risk for skin breakdown, did not receive Weekly Skin Integrity Reviews as required by facility policy and clinical standards of practice. Findings Include: A record review of the facility's policy Skin Evaluation with a revision date of 4/1/2017 revealed a license nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation form. Record review of the Weekly Skin Integrity Review documentation for Resident #35 revealed that it was completed only on 6/4/25, with no further documentation of weekly assessments as required, including after the initiation of a Quality Assurance and Performance Improvement (QAPI) intervention on 6/5/25. Interview with the Director of Nursing (DON) on 6/25/25 at 9:30 AM, confirmed that the facility became aware of the missed reviews on 6/4/25, but the QAPI plan had not been implemented effectively, and weekly skin checks remained undocumented for Resident #35. She revealed that inconsistently performing and documenting weekly skin integrity evaluations for a high-risk resident compromised early detection and treatment of skin breakdown. The Nursing Home Administrator (NHA) acknowledged in an interview on 6/26/25 at 10:25 AM that failure to follow through with the QAPI plan for skin assessments indicated noncompliance with established internal corrective strategies. A record review of Resident #35's Order Listing Report revealed a physician order dated 4/18/25, Clean re-open stage 3 pressure ulcer to left ischial with normal saline (NS), pat dry. Apply collagen powder to site. Cover with bordered foam dressing. A record review of Resident #35's admission Record revealed an admission date of 10/03/2019, with diagnoses including Contracture of Muscle, Multiple Sites. A record review of Resident #35's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2025 revealed a Brief Interview for Mental Status (BIMS) score of four (4), indicating severely impaired cognition.

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	06/26/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interviews, record reviews, and facility policy review the facility failed to provide perineal (peri) care in accordance with professional standards of care for one (1) of two (2) peri care observations (Resident #35). Findings include: A review of the facility's policy, Perineal Care, with a revision date of 9/5/2017, revealed, .Perform hand hygiene . On female residents, wash from front to back to avoid urethral or vaginal contamination . On 06/25/2025 at 10:23 AM, during an observation of wound care for Resident #35 provided by Registered Nurse (RN) 1, who is the Wound Care Nurse, and assisted by Certified Nursing Assistant (CNA) #5 revealed RN #1 stated to CNA #5 that the resident had a bowel movement. CNA #5 removed gloves and gown, sanitized hands, and exited the room. CNA #5 returned with a brief in hand and gown on. CNA #5 did not sanitize hands upon re-entry and applied clean gloves. He pulled out three peri wipes and wiped the anus three times front to back. CNA #5 asked RN #1 to assist in turning the resident over and applied a clean brief. CNA #5 did not perform peri care in the front vaginal area. On 06/25/2025 at 10:50 AM, during an interview, CNA #5 confirmed he did not wash the vaginal area. He stated the resident is contracted and hard to clean in the vaginal area. He acknowledged he did not fully complete peri care and was supposed to provide care to the vaginal area. On 06/25/2025 at 2:04 PM, during an interview, RN #1 confirmed that CNA #5 did not perform peri care in the vaginal area. She stated he was supposed to clean the vaginal area. She stated Resident #35 could develop a urinary tract infection (UTI) or skin breakdown from the care CNA #5 provided. On 06/26/2025 at 10:06 AM, during an interview, the Director of Nursing (DON) stated CNA #5 should have started peri care at the front and moved to the back. She stated Resident #35 was placed at risk for a UTI. A record review of Resident #35's Order Listing Report revealed a physician order dated 4/18/25, Clean re-open stage 3 pressure ulcer to left ischial with normal saline (NS), pat dry. Apply collagen powder to site. Cover with bordered foam dressing. A record review of Resident #35's admission Record revealed an admission date of 10/03/2019 with diagnoses including Contracture of Muscle, Multiple Sites. A record review of Resident #35's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/8/2025 revealed a Brief Interview for Mental Status (BIMS) score of four (4), indicating severely impaired cognition.

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	06/26/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and facility policy review, the facility failed to properly dispose of food and to seal open foods in bags to prevent the possibility of a foodborne illness for one (1) of two (2) kitchen tours. Findings include: A review of the facility's policy, Food Preparation, with a revision date of 2/2023, revealed, .Dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological and chemical contamination. On 06/23/2025 at 10:45 AM, during an initial kitchen tour with the Dietary Manager (DM), there was a ten (10) pound box of Sunkist oranges under the prep table, dated 6/10/2025. The box was three-fourths full, and three oranges had black and white mold. Gnats were observed flying out of the box when opened. Additionally, there was an unsealed bag of food thickener with a hole in it, exposed to the air. On 06/23/2025 at 11:14 AM, during an interview, the DM stated it was the cook's responsibility to dispose of the oranges. She confirmed the oranges were received on 6/10/2025 and acknowledged that both the oranges and thickener could cause foodborne illness. She stated it was her responsibility to check behind the cook and that all staff should date items when opened. On 06/23/2025 at 11:23 AM, during an interview, the cook stated she should have closed the thickener after use. She stated she checks behind the three dietary staff but was not paying attention in this case. She acknowledged the residents could get sick from improper food storage. On 06/25/2025 at 1:20 PM, during an interview, the Director of Food Services stated the Sunkist oranges should have been discarded. He stated the DM performs sanitation rounds five days a week and the thickener should have been sealed and dated. He acknowledged that the oranges could cause foodborne illness or a stomach virus, and the unsealed thickener posed a cross-contamination risk. He expects dietary staff to always serve safe food and provide high-quality service. On 06/26/2025 at 1:05 PM, during an interview, the Nursing Home Administrator (NHA) stated he expects staff to always maintain date compliance and store food appropriately.

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	06/26/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, staff and resident interviews, plan of correction review, and facility policy review, the facility failed to sustain an effective Quality Assurance and Performance Improvement (QAPI) plan as evidenced by one (1) re-cited deficiency originally cited in January 2024 on an annual recertification survey. This is for (1) of seven (7) cited deficiencies on the current annual recertification survey. Findings include: A review of the facility's policy, Policies and Procedures .Quality Assurance Performance Improvement, with a revision date of 11/30/2014, revealed, .Performance Indicators: 10. The center will establish performance indicators for data collected .Systematic Analysis and Action: The center will ensure systems and actions are in place to improve performance . A review of the Centers for Medicare & Medicaid Services (CMS) 2567 statement of deficiencies on the recertification survey from January 2024 revealed the facility was cited F677 for failing to ensure a resident's nails were clipped for one (1) of eighteen (18) sampled residents. On 6/23/2025, at 12:31 PM, Resident #57 was observed sitting on the side of her bed. The State Agency (SA) observed Resident #57's toenails appeared noticeably long and jagged. Resident #57 expressed that she would like assistance trimming them, noting that no one has come to help. A review of the current recertification survey from June 2025 revealed the facility was again cited F677 for failing to ensure a resident's nails were clipped for one (1) of nineteen (19) sampled residents. On 06/26/2025 at 11:52 AM, in an interview the Administrator, pointed out that while he cannot specifically identify the reason behind why the previous plan of correction (POC) for Activities of Daily Living (ADL) care is not currently being adhered to, he does say that he expects the designated staff to adhere to all grooming requirements set by the facility. During an interview conducted at 12:09 PM on 6/26/2025, the Director of Nursing (DON) suggested that the staff may be overlooking this aspect of grooming when providing care to residents, which could explain the lack of adherence to the original POC for ADLs.

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	06/26/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to provide perineal (peri) and wound care in a manner to prevent the possibility of spreading infection for two (2) of five (5) observations of care (Resident #35). Findings included: A review of the facility's policy, Hand Hygiene, with a revision date of 02/05/2021, revealed, Hand hygiene should be performed before initiating procedure, before and after care. A review of the facility's policy, Dressing Change, with a revision date of 12/06/2017, revealed, .Cleanse wound as ordered .dispose of gauze, remove gloves .perform hand hygiene . Apply treatment as ordered and clean dressing . On 06/25/2025 at 10:23 AM, during an observation of wound care for Resident #35 provided by Registered Nurse (RN)# 1, who is the Wound Care Nurse, and assisted by Certified Nursing Assistant (CNA)# 5 revealed RN #1 did not perform hand hygiene after initiating wound care. She stated to CNA #5 that the resident had a bowel movement. CNA #5 removed his gloves and gown, sanitized his hands, and exited the room. CNA #5 returned to the room with a brief and a gown on. He did not sanitize his hands before applying clean gloves. On 06/25/2025 at 10:50 AM, during an interview with CNA #5, he stated that he forgot to wash his hands when entering the room. He acknowledged that the resident could get an infection as a result. On 06/25/2025 at 2:04 PM, during an interview with RN #1, she confirmed CNA #5 did not perform hand hygiene before starting peri-care. She stated Resident #35 could get a urinary tract infection and skin breakdown due to the care CNA #5 provided. She confirmed that she failed to perform hand hygiene at each step of the wound care process. She stated she should have removed gloves and sanitized hands after each phase: cleansing, drying, applying collagen, and applying the dressing. She acknowledged that improper technique could result in a wound infection. On 06/26/2025 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) #3, who is the Infection Preventionist, stated she had recently completed in-service training on handwashing. She explained that RN #1 should have changed gloves and performed hand hygiene throughout the wound care process, and CNA #5 should have done the same before peri-care. She stated both staff placed the resident at risk for wound and urinary tract infections, including the possibility of introducing bacteria into the wound. On 06/26/2025 at 10:00 AM, during an interview with the Director of Nursing (DON), she stated RN #1 should have changed gloves and performed hand hygiene throughout the wound care process. She confirmed that Resident #35 was at risk of wound infection. She stated CNA #5 should have performed hand hygiene before putting on gloves to complete peri-care. She stated Resident #35 was placed at risk for urinary tract infection (UTI). A record review of Resident #35's admission Record revealed an admission date of 10/03/2019, with diagnoses including Contracture of Muscle, Multiple Sites, and Essential Hypertension. (continued on next page)

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	06/26/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #35's Order Listing Report revealed a physician order dated 4/18/25, Clean re-open stage 3 pressure ulcer to left ischial with normal saline (NS), pat dry. Apply collagen powder to site. Cover with bordered foam dressing. A record review of Resident #35's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2025 revealed a Brief Interview for Mental Status (BIMS) score of four (4), indicating severely impaired cognition.