STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oxford Health & Rehab Center	1301 Belk Boulevard Oxford, MS 38655

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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
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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 0697 Level of Harm - Actual harm Residents Affected - Few	Based on resident representative and staff interview, record review, and facility policy review, the facility failed to ensure pain management was provided for a resident that had diagnoses that included pain and chronic pain for one (1) of six (6) residents sampled. Resident #1Findings include:Record review of facility policy titled, Pain Management with a revised date of 3/10/25, revealed, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .During a phone interview on 10/1/25 at 12:17 PM, Resident #1's representative revealed the resident had multiple wounds and was on antibiotics and was admitted to the facility from the hospital late in the evening on 7/25/25 and was sent back to the hospital on 8/6/25 and passed away on 8/25/25. She stated when the resident returned to the hospital it was determined that she had a decreased blood supply to her lower body and this caused excruciating pain. She stated that during the facility stay, the resident requested her pain medication and several times she did not receive it at all, or it was given long after it was requested. She stated it was unacceptable for the resident to have been in such severe pain and to not have the ordered medication given to her timely.A phone interview with Licensed Practical Nurse (LPN) #1 on 10/2/25 at 8:30 AM, revealed she was the nurse that admitted Resident #1 to the facility. She stated the resident had multiple wounds and complained of severe pain on admission, but she did not have pain medication available to administer to the resident. She confirmed she did not follow the process of obtaining pain medications for a resident with pain and she did not contact the pharmacy or the physician. She revealed a pain scale score was not checked or documented, but the resident had significant pain during part of her shift, and when the medication arrived around 3:00 AM, the resident was asleep. She stated the resident's condition was a sad situation and she had pain from the moment she was admitted till she left that shift. An interview with the Director of Nursing (DON) on 10/1/25 at 2:30 PM and 10/2/25 at 9:35 AM, revealed Resident #1 was admitted to the facility with multiple wounds and cellulitis of the perineum. She stated the facility had a system in place to allow medications to be obtained any time day or night through their medication dispensing system which could be accessed prior to medications delivered by their pharmacy. She acknowledged if a pain medication was needed, the on-call pharmacy provided a code for the narcotic to be obtained from the dispensing system. If no prescription was available, the provider would be notified to send a hard copy of prescription to the pharmacy so the staff could obtain the needed medication for the residents. After Resident #1's admission Health Status Note by LPN #1 which indicated the resident was having pain and medications were not available, was reviewed by the DON, she acknowledged this should not have occurred since the medication was available in their dispensing system. She acknowledged that a pain level score was not documented by LPN #1, but the nurse had documented in the progress note that the resident was experiencing pain. She acknowledged that each resident has the right to receive the care necessary and it was her expectation that each staff member follows the process to obtain the needed medications for each resident. She confirmed the nurse, therefore the facility, failed to follow the procedure for obtaining medication for a resident experiencing pain. Record review of Resident #1's Health Status Note dated 7/25/25 at 9:30 PM, revealed, Resident is complaining of pain at this time, but no medications are on hand for her. This was signed by LPN #1.Record review of Resident #1's Order Summary Report revealed an order dated 7/25/25 for Hydrocodone-Acetaminophen Tablet 5-325 milligram (mg) give one tablet by mouth every 8 hours as needed for pain.Record review of the Electronic Medication Administration Record (EMAR) revealed Resident #1 did not receive the ordered pain medication on 7/25/25.Record review of facility's Inventory list for medications in the dispensing system revealed that Resident #1's ordered medication, Hydrocodone/Acetaminophen 5-325 mg was available in the facility's medication dispensing system.Record review of Resident #1's admission Record revealed an admission date of 7/25/25, with diagnoses that included cellulitis of perineum, pressure ulcer, pain, and chronic pain.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating Resident #1 was cognitively intact.