STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on staff and resident interview, record review and facility policy review the facility failed to protect a resident's right to be free from misappropriation of property for one (1) of five (5) sampled residents. Resident #1. Findings include: Record review of the facility's, Abuse Prohibition Policy with revision date of 11/07/23 revealed, The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Record review of the facility policy, Resident Rights with a revision date of February 2021 revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .c. be free from abuse, neglect, misappropriation of property, and exploitation Record review of the facility Investigation of the allegation reported to Administrator by Resident #1 revealed that she had previously allowed Certified Nursing Assistant (CNA) #1 to order her some food on her food application (app) on her phone because she did not have a way to place the order. She gave CNA #1 her debit card number to use and then discovered on 08/04/24 that there was a pending charge of $9.99 on her bank account from the same food delivery service that the CNA had used prior. During the investigation, they found that when Resident #1's card was uploaded, it was set up for a monthly trial subscription and if canceled before the trial was over, it would not charge the monthly fee. It was also found that CNA #1 asked Resident #1 to buy her lunch on 07/07/24 and she would pay her back. As of 08/06/24, CNA #1 had not paid Resident #1 back. On 08/06/24, CNA #1 came into the facility and brought the money owed and it was given to Resident #1. Resident #1 was also reimbursed for the monthly subscription fee of $9.99. This incident was reported to State Agency, Attorney General's Office, the Local Police, the Medical Director, Ombudsman, and Resident #1's spouse. Staff were in-serviced on Abuse/Neglect, Resident Rights and Misappropriation. Life Satisfaction Rounds were completed with no other negative findings. CNA #1 was suspended pending investigation and then terminated. (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
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 9:55 AM, an interview with Director of Nursing (DON) revealed that CNA #1 used Resident #1's debit card on 07/07/24 ordered some sushi and never paid the resident back. She revealed that Resident #1 reported to her that CNA #1 had told the resident that she had been on vacation and needed to borrow money for food. The DON revealed that Resident #1 allowed CNA #1 to order food with her debit card and CNA #1 agreed to pay her back on payday. The DON stated that Resident #1's husband noticed a pending charge on their bank account and called Resident #1 and discovered that it was a charge that she had not incurred. During the investigation, they found that CNA #1 had used Resident #1's debit card several times without her permission and ordered food and had it delivered. The DON confirmed that they called CNA #1 to come to in and she paid Resident #1 the $20.00 that she owed her, and they terminated CNA #1. She revealed that CNA #1 knew that she was not supposed to take anything from a resident and was not supposed to use a resident's debit card for any purchases. DON revealed that they provided training on abuse, neglect and misappropriation of resident property upon hire and routinely and had just had a training a couple months ago. On 09/30/24 at 11:45 AM, an interview with Staff Development Coordinator (SDC), revealed that she conducted an in-service on Abuse, Neglect, and Misappropriation of Property with all staff 07/17/24 through 07/18/24 and CNA #1 attended. She revealed that using someone's debit card was unacceptable and it was misappropriation of a resident's funds. The SDC revealed that CNA #1 used Resident #1's personal debit card to order food and some of the food was for herself. She also revealed that some of the staff had witnessed CNA #1 asking other staff members to buy her lunch. SDC revealed that CNA #1 was suspended immediately pending investigation and was terminated later. On 10/01/24 at 8:35 AM, an interview with CNA #3, revealed that she worked the night that CNA #1 used Resident #1's debit card. CNA #3 stated that she came into the facility and CNA #1 was eating sushi and told her that she had ordered it through a food delivery service. CNA #3 revealed that a couple weeks later, Resident #1 told a staff member that her husband questioned a charge on her bank statement, they investigated and found that CNA #1 had saved Resident #1's debit card information on her cell phone and used it to buy herself food. CNA #3 revealed that CNA #1 came in, paid the money back to Resident #1, and they terminated her. CNA #3 confirmed that this was a misappropriation of resident property and was a major issue. She revealed that they were not supposed to accept anything from a resident. On 10/01/24 at 9:38 AM, an interview with the Administrator (ADM) revealed that when hired, all staff members completed training on Abuse, Neglect and Misappropriation of Property. He revealed that the staff knew not to take anything from a resident, not even a piece of peppermint. He stated that CNA #1 knew better but did it anyway. He revealed that they reported it to the State Agency and to the Attorney General's Office, suspended her immediately pending investigation and then terminated her. On 10/01/24 at 10:45 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed that CNA #1 initially ordered food for a resident and for herself using Resident #1's debit card. She revealed that Resident #1 told her that CNA #1 had asked on another occasion to order her some food again and that she would pay her back, but she never did. LPN #1 revealed that CNA #1 continued to use Resident #1's debit card and had it saved in her own phone. LPN #1 revealed that CNA #1 did not pay the resident back until they confronted her about it. LPN #1 revealed that CNA #1 asked frequently for people to buy her food and asked for donations for her daughter. She revealed that she had used Resident #1's card more than once. LPN #1 confirmed that they investigated this and CNA #1 was fired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 12:34 PM, a phone interview with Resident #1 revealed that she had been in that facility three different times and really enjoyed it. She revealed that when she was in the facility this last time, CNA #1 took right up with her, and she thought she was her friend. Resident #1 revealed that one night she decided to order three or four pizzas for the night shift because they had been good to her and she wanted to show her appreciation. She stated, That's just how I am. Resident #1 revealed that CNA #1 offered to order through her phone application (app) and have it delivered for me. Resident #1 confirmed that CNA #1 took her debit card information and placed the order for her. CNA #1 told Resident #1 that her phone was messing up so she would just use her own cell phone to place the order. Resident #1 revealed that CNA #1 took her debit card and placed the order. Resident #1 stated that on another day, CNA #1 told her that she had just returned from vacation and didn't have any money and asked her if she could order her some food and she would pay her back when she got paid. Resident #1 revealed that on 07/07/24, CNA #1 ordered food using Resident #1's debit card, for both Resident #1 and herself, but CNA #1 did not pay her back. Resident #1 revealed that on 08/05/24, her husband called questioning her about a pending charge on her bank account and she reported to the Administrator that she had allowed CNA #1 to order food on her app because she did not have one. She revealed that they researched it and found that CNA #1 had used Resident #1's debit card and signed her up for a monthly subscription to have the food delivery service and that her debit card was linked to CNA #1's email address. Resident #1 stated, I did not give my card to her to do what she wanted with it. Resident #1 revealed that she thought CNA #1 was her friend and that she shouldn't take from people. Resident #1 also revealed that CNA #1 was real smart about it and she felt sorry for CNA #1 and she didn't press charges because she knew she had a little girl and didn't want her to suffer because of it. Resident #1 revealed that when the Administrator called CNA #1 in, she reimbursed her twenty dollars, and she revealed that the subscription fee of $9.99 was reimbursed as well. Resident #1 revealed that CNA #1 was fired, and she hoped that she never did anyone else like that. Resident #1 confirmed that the food receipt dated May 23, 2024, for the total amount of $31.59 was for the food that was ordered for she and CNA #1 and confirmed that CNA #1 had paid what she owed for her part on that charge. Resident #1 also confirmed the last four digits of her Visa debit card. During the interview, Resident #1 revealed that she had not approved the charges to her card on 06/02/2024 for $64.89 which was a food order placed by CNA #1. She revealed that she didn't eat sushi and that she had only agreed to let CNA #1 order using her card two times, the very first time when she ordered pizza and then again on 07/07/24 when CNA #1 asked her to buy her lunch. Resident #1 revealed that she had missed this somehow and she hadn't been reimbursed for this charge. When asked about the $3.00 and the $3.36 tip charges to her debit card on the food receipts from an order placed by CNA #1 dated June 02, 2024, Resident #1 revealed that she was not aware of those charges and had not been reimbursed for that amount. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 12:55 PM, a phone interview with CNA #1, revealed that on 06/2/24, Resident #1 asked her to order her food through her phone app and she used the resident's debit card to pay for it. CNA #1 revealed that another day, CNA #1 asked Resident #1 if she could order herself some food and stated, I said I'd pay her back. CNA #1 revealed that Resident #1's debit card was charged for a monthly subscription fee and she didn't know how that happened. CNA #1 revealed that Resident #1 left the facility before she could pay her back, and she felt bad about it. CNA #1 revealed that one day the Administrator called her into the facility, she went in and paid Resident #1 back. She revealed that she knew she was not supposed to use a resident's debit card to order her food, and she knew she shouldn't have asked the resident to buy her food even if she was going to pay her back. CNA #1 stated, I'm sorry that it happened and never intended it to happen like that. I felt bad that it happened. She revealed that if she had it to do over, she would refer Resident #1 to eat in the cafeteria and not order out. CNA #1 agreed that this was a misappropriation of resident funds and that this was a serious offense. She confirmed that she had been in-serviced on this and that she knew better. CNA #1 confirmed that she had training during orientation on resident abuse, neglect, and misappropriation of resident property and that she knew she was not supposed to take anything from a resident. She revealed that the first two times she used Resident #1's debit card, that the resident offered to buy my food, and I let her. CNA #1 revealed that she didn't know how those other charges for tips got charged to the resident's card and denied having Resident #1's debit card information saved to her phone. She stated, I don't know how that happened. On 10/04/24 at 8:23 AM, after exit from the building and further record review it was reported to Administrator by phone that during the investigation, it was found that other amounts including $64.89, $3.00, and $3.36 were charged to Resident #1's debit card on 06/02/24. Administrator revealed that he was not aware of these other charges, he would put in a request for the total amount of $71.25 and get it reimbursed to her. Record review of the food receipt dated 06/02/24 revealed that $64.89 charged to Resident #1's debit card and that CNA #1 placed the order for delivery. There was also a $3.00 charge and a $3.36 charge to Resident #1's debit card on 06/02/24 and was documented as tips. Record review of the food receipt dated 07/07/24 revealed that $3.00 was charged to Resident #1's debit card for the food ordered by CNA #1 and the food was delivered to the facility. Record review of CNA #1's Personnel Action Form revealed that she was suspended on 08/05/24 and that she was terminated on 08/08/24. Record review of CNA #1's Disciplinary Action Record dated 08/08/24 revealed that she was terminated for misappropriation of funds. Record review of CNA #1's Statement received on 08/06/24 over the phone by administrator revealed that on 06/02/24, Resident #1 asked CNA #1 to order her some food off of a phone app. She then ordered again through the phone app and Resident #1 ordered CNA #1 food as well on 07/07/24. CNA #1 had told Resident #1 she would pay her back. CNA #1 didn't know that Resident #1's card was set up for the monthly subscription fee. Resident #1's card has been taken off of CNA #1's account and the monthly subscription fee is being refunded. CNA revealed that she didn't know it was charging her because she thought her card was deleted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA #1's Time Card dated 05/23/24 through 07/07/24 revealed that she worked on 05/23/24, 06/02/24, and 07/07/24 and was clocked in at the facility at the time Resident #1's debit card was used to purchase food delivery. Record review of CNA #1's Time Card dated 07/25/24 through 08/07/24 revealed that she last worked the night shift on 08/04/24. She clocked in at 6:54 PM and clocked out at 7:09 AM on 08/05/24. Record review of Resident #1's Admission Record revealed an original admitted [DATE]. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/10/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on resident and staff interviews, record review, and facility policy review the facility failed to provide sufficient staffing to ensure residents needs were met in a timely manner for five (5) of seven (7) residents reviewed. Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7. Findings Include: Record review of the facility policy, Staffing, Sufficient and Competent Nursing with reviewed date of 03/2023 revealed, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety, b. attaining or maintaining the highest practicable physical, mental, and psychosocial well being of each resident .d. responding to resident needs. On 09/30/24 at 9:50 AM, an interview with Director of Nursing (DON), revealed that staffing was rough, and they were worn out. She revealed I don't' have a life because of this job and observed a pair of rubber boots in her office and DON revealed that she and the Assistant Director of Nursing (ADON) had to cover some weekend Certified Nursing Assistant (CNA) shifts, they gave showers and did whatever needed to make sure the residents were taken care of. The DON confirmed that they had an On Call rotation and if staff called in or didn't show up, the on-call person had to get the shift covered. She revealed that if the on-call person couldn't find shift coverage, she was responsible and had to come in herself and cover it. DON revealed that she had her own job to do, and as many shifts as they have had to cover lately, she felt like she was drowning. She revealed that one on-call nurse couldn't cover all the shifts because there was usually more than one position needing coverage, especially at night. DON revealed that they had a lot of staff turnover, a lot of staff calling in and she had received a notice from a Registered Nurse (RN) Supervisor this morning who was quitting so that's one more position needing to be filled. She confirmed that they just couldn't keep anybody the way things were with staffing issues and stated, It's too much. DON revealed that they offer bonuses for staff to come in but that it had decreased from what it used to be so there were no incentives for staff to show up to work anymore. The DON revealed that the corporate office refused to allow them to use agency staff to help cover the shortage until a couple weeks ago. She confirmed that they could only use three agency CNAs per day on the weekends which included Friday, Saturday, and Sunday. DON confirmed that staffing was bad, and there were not enough people and the resident care suffered because of it. On 09/30/24 at 10:24 AM, an interview with Resident #3 revealed that they seemed to have enough staff during the day, but not so many at night. She revealed that some nights they only had two aides working and they had to take care of a whole hall by themselves. Resident #3 revealed that she had to get her daughter to cut her toenails the last time because she had asked the nurse to do it, and it never got done. She confirmed that the staff were good to her, they respected her and took care of her and stated, They are just shorthanded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/24 at 10:40 AM, an observation and interview with Resident #7 revealed they were short-staffed a lot, especially at night. She revealed that one night a couple weeks ago, she pressed her call light to go to the bathroom and it took them an hour and a half to answer the light. The resident revealed that she required help to go to the bathroom and they waited so long about coming that she nearly wet herself. She revealed that it was hard to wait that long, because when she had to go to the bathroom, she needed to go right then, not wait forever. Resident #7 revealed that there were other times when she had to wait 30-45 minutes for her call light to be answered. She revealed that the staff were good to her, and guessed they were doing the best they could because they were so busy. On 09/30/24 at 11:00 AM, an interview with CNA #4 revealed that they were short-staffed, and did not have enough CNAs to handle the workload. She revealed that she was previously a shower aide but due to CNA shortage, they did away with that position and pulled her out on the floor. She revealed that now this was more work for everyone, it created more chaos and stated, It's a lot to take care of and we work twelve-hour shifts. CNA #4 revealed that staffing had been an on-going problem, and she worked extra when she could. CNA #4 revealed that the quality of care goes down with increased responsibilities and stated that they had to give showers, answer call lights, make incontinent rounds, help with snacks and hydration, and pass out meal trays at breakfast, lunch and dinner and help feed the residents for about 15-20 residents per shift and sometimes more if someone calls in. CNA #4 revealed that they needed to do something to make things better and stated, These residents should be our top priority. On 09/30/24 at 11:20 AM, an interview with Staff Development Coordinator, revealed that they had gotten away from using a shower team because of staffing changes. She confirmed that they became short on CNAs and had to pull the shower team and restorative aids out to work on the floor. She confirmed that the CNAs did their own showers, they divided the workload, and each CNA had to do three showers a shift. Staff Development Coordinator revealed that she kept an On-Call Calendar, and the Department Heads rotated being on call and that if a shift was short and needed coverage, the on-call nurse was responsible to get it covered or they would come in and cover it. She revealed that some of the nurses have had to come in and work as CNAs and they just pulled together to get the job done. Staff Development Coordinator revealed that they currently had seven open positions for CNAs that needed to be filled. She revealed that their primary focus and greatest need right now were CNAs. On 09/30/24 at 11:55 AM, an interview with Resident #4 revealed that he had been in the facility almost a year. He revealed that they were short of people, and it was worse at night. He revealed that sometimes they had two (2) aides at night for the whole building and sometimes they had four. He stated, Sometimes they'll get to you and sometimes they won't. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/24 at 12:00 PM, an interview with CNA #2, revealed that staffing was rough and worse on night shift. She revealed that they were overworked. She stated that they were okay with three (3) CNAs on night shift but sometimes they only had two CNAs and that was very hard to handle. CNA #2 revealed that they had two Licensed Practical Nurses (LPNs) at night on the medication carts and some of them would help answer call lights if they were short staffed, but some would not. She revealed that the residents were noticing and complaining more about not getting their call lights answered timely and not getting what they needed. CNA #2 revealed that working short staffed made it hard to get to the residents and answer their call lights in a timely manner. She revealed that she stayed over one day last week, and worked from 6 AM to 11 PM until the other shift came in and stated, It's rough. CNA #2 revealed that working 16-18 hours a day was not fair to them or the residents. She stated that they had been doing job fairs and hiring and they could get new staff into the facility, but once they find out the workload, they don't stay. She revealed that the DON and ADON were good to come out of their office and work the floor if needed and had even worked as CNAs on the weekends lately. She revealed that they offered $50 bonuses to come in and work extra but the bonuses had dropped from what they used to be. She stated that she received text messages nearly every day about shifts that needed coverage, and that the day shift was hard, they had three meals to pass out, give showers, make beds, pass out ice and hydration and answer call lights and provide incontinent care. On 09/30/24 at 2:53 PM, an interview with Resident #6, revealed that when they had enough staff, they gave decent care. She revealed that the people in the office who run this place, Do the best they can. She revealed that they were short of CNAs and that she had to wait over an hour for care not long ago. She confirmed that she was not able to get up by herself and she wore a diaper and that they were so short staffed one night, that she had to wear a diaper that was soaked with urine for over an hour before they could get to her to change her. She said, I told them they must be really busy. She revealed that they were short staffed yesterday, they don't have enough people to work. She confirmed that she has had to wait over an hour for her call light to be answered several times lately but maybe it would get better. Resident #6 revealed that the girls in the office had to come out on the floor and work lately and said it was ridiculous sometimes. She revealed that she pressed her call light yesterday and it took them an hour to answer and when the staff finally came in, she had forgotten what she needed. She stated, If it's something I need, I might as well get it myself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/24 at 3:30 PM, an interview with CNA #5, revealed that she had worked at that facility since 2005, and they didn't have the staff and teamwork they used to. She revealed that they were all tired and frustrated and that the weekends were horrible and stated, Sometimes it's a nightmare around here. She revealed that a lot of days, they didn't have enough people to take care of the residents, and the nights were the worst. She revealed that this was unfortunate for the residents because they should come first. CNA #5 revealed that their sister facility didn't have the issues they were having, and she didn't understand why they couldn't get the staff they needed. She revealed that the department heads had to come in and help them often and still had to do their jobs as well. CNA #5 revealed that one night not long ago, they had only two CNAs come in on night shift, she took one hall, and the other CNA took the other hall. She revealed that it was four hours before they got another person to come in to help. She revealed that at that time, the census was in the 50s and it was very hard to take care of everyone. She revealed that sometimes they had more than one call light going off while making their rounds and they couldn't get to everyone at once, it was so overwhelming and stated, I'm burned out now. CNA #5 revealed that the department heads had an on-call rotation and were supposed to come in if they couldn't find coverage, some would come in and some would not. CNA #5 revealed that coming in early and leaving late was tiring but those residents needed to be taken care of. She stated, We help each other out the best we can. She revealed that they needed some help and just wanted enough staff to care for the residents and stated, They are the reason we have a job. She revealed that it made it so hard on them to not have sufficient staff, and stated, It's pure exhaustion. She confirmed that there was a time when she loved her job but now, she had to pray hard before coming in to work, and that's sad. She stated that the administrator should care enough to get them adequate staffing and stated that it all trickled down from management, if the Administrator didn't care for his staff, they couldn't care for the residents. On 09/30/24 at 4:06 PM, an interview with Resident #5, revealed that she had a stroke, she couldn't walk and was in the facility for therapy. She stated that they were short-handed and at night You might see an aide one time or might not see one at all. Resident #5 revealed she didn't know why they had call lights; it took thirty minutes to an hour to get it answered especially at night. She revealed that sometimes when she pressed her call light and they would come in, push the call light off and tell her they would be back because they were so busy. She stated, Sometimes it takes a while for them to come back. Resident #5 revealed that sometimes at night, the aide would change her around ten or eleven and then she may not see her again until four or five the next morning. She revealed that she didn't like to bother anybody but when she pressed her call light, she needed them to answer it. Resident #5 revealed that she could not get up without help and sometimes she had to lay in a soaked diaper until they could get to her and stated, If I could walk myself, I wouldn't bother anybody. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 8:20 AM, an interview with CNA #3, revealed that staffing was bad here and that they hadn't had agency staff in months and all of a sudden, they called an agency CNA in last night because State was in the building. CNA #3 stated, There ain't no night shift. She revealed that she worked back and forth between days and nights to help out, but it was rough. She revealed that they only had one full time CNA on each night shift rotation and that was it. She stated that they fluffed the schedule and had people on there that were notorious for last minute call ins or just not show up and there were no repercussions for this. She confirmed that she was full time and a lot of nights, there was only she and one other CNA working the whole building. She revealed that when they had two CNAs working, they divided the residents and that was usually twenty-five to thirty residents each to take care of. She revealed that they didn't get much help from the nurses either because they had their job to do and was busy passing medications. CNA #3 revealed that on the nights they only had 2 CNAs, they called the on-call nurse, sometimes they would get someone to come in four or five hours later and sometimes they wouldn't have anyone to come in. CNA #3 revealed that they called an agency CNA in last night and that one came in around 11:00 PM and that made a total of three CNAs in the facility. She stated, A lot of nights they only had 2 CNAs and said by the time she made her rounds, sat down for a minute, it was time to do it all over again. She revealed that it was hard to give three resident showers, make rounds, and answer call lights with only two CNAs on the floor. CNA #3 revealed that they were supposed to get five residents up before the end of their shift but if it was only two of them working, they just checked residents and changed them. She confirmed that many of the residents required more in-depth care and required lifts and two-person assistance with transfers and that was hard if there were only two CNAs in the building. She stated that the administrator didn't seem to care, that he's never been up there helping out in a shortage. CNA #3 revealed that they bring new staff through the door, but many don't want to work and they don't stay. She revealed that they didn't seem to be doing anything to keep the staff they had either, no incentives to work night shift or cover extra shifts and they just kept losing people. She revealed that she decided she was going to go back to day shift soon because it was just too much to handle. She revealed that she worked ten or eleven days straight often and swapped back and forth between day and night shifts because of the shortage and that they got group texts all the time needing shifts covered. On 10/01/24 at 9:40 AM, an interview with DON revealed that they had monthly Resident Council Meetings and if any concerns were brought up, the Activities Director brought the concerns to the appropriate Department Heads, and they had to sign off that the issues were addressed. She revealed that the Resident Council Meeting Minutes from August were brought to her attention yesterday on 09/30/24, and she had not been made aware that low staffing was brought up from the residents in the meeting. On 10/01/24 at 10:00 AM, an interview with DON revealed that they were short staffed last night and that there were two CNAs and one of them left at 11:00 PM. She revealed that they ended up calling an agency CNA in and that normally agency staff were only utilized on the weekend, but Administrator approved it since state surveyor was in the building for a complaint regarding staffing. She stated, We don't need a state fix, we need a resident fix. On 10/01/24 at 10:09 AM, an interview with Staff Development Coordinator, revealed that they did not have anything in place to retain the staff they had but had talked about the need. She revealed that they offered fifty-dollar bonuses for picking up extra shifts and twenty-five dollar bonuses to work extra hours on their scheduled days. She revealed that they used to give one-hundred-dollar bonuses to work extra shifts but they had gone down some and that they posted open shifts that needed to be covered, sent out group texts and she could add in or take off as shifts were spoken for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 10:55 AM, an interview with LPN #1 revealed that staffing had been terrible and was worse when they decided not to use agency any more through the weekdays. She revealed that some nights there were only two CNAs working with fifty something residents. LPN #1 revealed that they had some really sick people and there was no way to monitor and take care of the residents the way they deserved with only two CNAs. On 10/01/24 at 11:40 AM, an interview with Resident #5 revealed that she didn't remember seeing anybody through the night last night and stated that a CNA came in and changed her before she left around eight last night and a CNA came in this morning and checked on her, but other than that she had not seen anyone. On 10/01/24 at 9:08 AM, an interview with the Activities Director, revealed that she was new to this position and that the August Resident Council Meeting was the first one she held without assistance. She revealed that during the meeting on 08/22/24, Resident #3 brought up that the nurses and CNAs did not answer call lights timely and that the aides checked on them one or two times a night and did not make their regular rounds. Activities Director revealed that she followed up with the residents a week later, and they told her that things were about the same. She revealed that some days were good with staffing and some days were not. She revealed that she filled out the Resident Council Minutes at each meeting and brought any issues to the department head specific to the identified concern and they would follow up and had to sign off on it. On 10/01/24 at 1:20 PM, an interview with Administrator revealed that he felt like they had adequate staffing and that they always staffed above the required state ratio and he wasn't aware of any resident concerns regarding staffing. He revealed that they had on-call staff on rotation and when they had call-ins or no-shows, they either found someone to cover the open shifts or they came in themselves and covered the shift. He revealed that when there was a need, administrative staff would go to the floor and do what needed to be done and that some of the nurses worked as CNAs when the need was there. Record review of Resident Council Minutes from the meeting held on 08/22/24, revealed concerns related to staffing. Documentation revealed Nursing Issues: Night shift doesn't check regularly only once or twice the whole night. The DON acknowledged and signed this on 09/30/24. Record review of the Staffing Grid completed and verified by Staff Development Coordinator, revealed that on 09/01/24, there were two CNAs working on the 11 PM - 7 AM shift and the census was fifty. Record review of a list provided by the facility revealed that ten residents required the use of a total lift x 2 staff members for transfers. There are fifteen residents that required the assistance of two staff members for transfers to wheelchair and two residents that require the use of a sit-to-stand lift x 2 staff members for transfers, for a total of 27 residents out of a census of 45 that require two person assist with all transfers. Record review of the Open Positions list revealed that the facility had seven (7) open CNA positions for the 7 AM - 7 PM shift, had six (6) open CNA positions for the 7 PM - 7 AM shift, and two (2) Registered Nurse (RN) Supervisor positions open for the 7 AM - 7 PM shift, a total of fifteen immediate open positions that were needed for the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Oaks Rehabilitation and Healthcare Center	111 Chase Street Byhalia, MS 38611

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review or Resident #3's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Chronic Kidney Disease, Type 2 Diabetes Mellitus, and Need for Assistance with Personal Care. Record review of Resident #3's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/30/24 under Section revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact. Record review of Resident #4's Admission Record revealed an admitted [DATE] and diagnoses that included Peripheral Vascular Disease and Need for Assistance with Personal Care. Record review of Resident #4's MDS with ARD of 08/08/24 under Section C, revealed a BIMS score of 15 which indicated that he was cognitively intact. Record review of Resident #5's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Cerebral Infarction, Type 2 Diabetes Mellitus, and Need for Assistance with Personal Care. Record review of Resident #5's MDS with ARD of 08/20/24 under Section C revealed a BIMS score of 9 which indicated that he had mild cognitive deficits. Record review of Resident #6's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Anemia, Adult Failure to Thrive, and Need for Assistance with Personal Care. Record review of Resident #6's MDS with ARD of 07/30/24 under Section C revealed a BIMS score of 12 which indicated that she had mild cognitive deficits. Record review of Resident #7's Admission Record revealed an admitted [DATE] and that she had diagnoses that included a Displaced Oblique Fracture of Shaft of Humerus of Right Arm, Muscle Weakness, and Need for Assistance with Personal Care. Record review of Resident #7's MDS with ARD of 07/30/24 under Section C revealed a BIMS score of 12 which indicated that she had mild cognitive deficits.