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	05/22/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47874 Based on observations, resident, staff, and family interviews, record review, and facility policy review, the facility failed to maintain a safe environment and provide adequate supervision and equipment to prevent accidents for one (1) of four (4) sampled residents. Resident #1. Specifically, staff removed the resident's bed rails without a safety assessment and as a result, the resident rolled out of bed, during care and sustained a head laceration, suffered pain and required emergency room treatment, including x-rays and stitches. Findings Include: Review of the facility policy titled Fall Prevention Program with a review date of 6/10/24 revealed under, Policy: All residents will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change thereafter. Based on the results of this assessment, specific interventions will be implemented to minimize falls, avoid repeat falls and minimize falls resulting in significant injury. Record review of the NSG (Nursing): Device Evaluation dated 11/26/24 revealed under, Fall History . fell within last 30 days . Resident has a history of falls from the bed was indicated. Also revealed under, Side Rail Usage Determination . B. 1/2 (one-half) Partial Rail was indicated for right and left upper bed. Additionally, revealed under, H. Side rails at all times when in bed was indicated. Record review indicated an assessment was not completed when the side rails were removed to evaluate if the resident was safe without them. Record review of Resident #1's Progress Notes dated 4/10/25 revealed, This nurse was preparing for report when 7p (PM) -7a (am) supervisor informed me that someone on my hall was yelling help. Upon arriving in the room, the resident was noted to be on the floor flat on her back looking up at the ceiling. Resident's head was propped on top of the bar on the bottom of the bedside table. Blood stain noted to be on it. Blood is noted to be dripping in front of the forehead onto the floor. A puddle of blood is noted to be on the floor under the resident's head as well. Arms crossed over chest and the resident stated her right arm hurt . Skin assessment performed; laceration noted to right side of forehead, wound care performed. Cleaned with wound cleanser, abd (abdominal) pad placed .911 called, resident transported to Proper name of hospital ER (emergency room) @ (at) 7:25 PM. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the emergency room Records dated 4/10/25 revealed Resident #1 had a Cat Scan (CT) of cervical spine with no acute findings. The CT of the head revealed findings of hematoma and subcutaneous emphysema in the frontal scalp near the midline. Record review of Resident #1's Progress Notes dated 4/10/25 revealed, Report received from (Proper name of hospital), stated that the resident will be returning to the facility. CT (cat scan) negative. Read soft tissue injury from laceration. New order for ABT (antibiotic) amoxicillin 875/125 mg (milligram), and 7 (seven) suture on forehead. Record review of Resident #1's Progress Notes dated 4/11/25 revealed, SW (Social Worker) and ADON (Assistant Director of Nursing) met with family to answer questions about side rails for the bed. It was explained that it was against state regulation to have the full side rails. Daughter is very upset and does not feel it is safe for her mother not to have bed rails. An observation of Resident #1 on 5/22/25 at 8:40 AM revealed she was lying in bed with the head of bed elevated. The resident had an air-loss mattress, assist bars on both sides of the bed and a fall mat located on the right and left side of the bed. The resident was awake and talkative. She was able to recall that she was reaching for the table when she rolled out of the bed. She stated, I had stitches up there indicating to her forehead which had a pink one-inch scar. An interview with Licensed Practical Nurse (LPN) #1 on 5/22/25 at 9:04 AM revealed the day Resident #1 fell , she was sitting at the desk, and it was almost shift change. She explained she heard hollering, so she went to check. She stated the resident was lying on her back on the floor on the right side of the bed with her head lying on the bottom base of the bedside table. She revealed the resident had blood all over the floor and the bedside table coming from a laceration to her forehead and further explained that her right arm was bruised. She revealed the aide was still in the room and explained that she had turned the resident onto her left side and reached back to get some supplies and the resident was already rolling off the mattress. She explained that the resident had stitches to the forehead laceration, but nothing was broken. She confirmed she was bruised up badly to her arm and face following the fall and that after the fall, they implemented fall mats on both sides of the bed and the family requested the assist bars. An interview with Certified Nurse Aide (CNA) #1 on 5/22/25 at 9:12 AM revealed she looked at the computer charting system to determine how many staff members were required to provide this resident's care. She revealed if a resident was down for a two person assist, they could not provide the care unless another person was present. She revealed Resident #1 was a two person assist with care, but wasn't sure if she was a two person assist when the fall occurred. A telephone interview with a family member of Resident #1 on 5/22/25 at 9:17 AM revealed she believed the aide turned Resident #1 over in bed and that she just kept rolling. The family member revealed Resident #1 had bed rails, but the facility had removed them due to a Mississippi Law without giving them a choice. The family member explained that she was told the facility could not use them, and the rail was a restraint. The family member stated, We didn't want them removed. She explained that Resident #1 was able to use them to hold onto when they turned her over. She stated we demanded they put something on after she fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with the Assistant Director of Nursing (ADON) on 5/22/25 at 9:34 AM revealed that all the bed rails were removed from the facility following a change in company policy which was a long time ago, but could not provide an exact day or month. She explained after the fall on 4/10/25, she met with the family who requested bed rails for safety and the assist bars were approved through the administrator and applied per the family request. Record review of the Order Summary Report for Resident #1 revealed an order dated 4/11/25, Routine monitoring of assist bar(s) and other PSD (patient safety devices)/enablers will be done via visual checks q (every) shift for entrapment risk, restraining effect and function, every shift for per family request. Record review revealed a side rail assessment was not conducted upon applying the assist bars on 4/11/25 per family request. A telephone interview with CNA #2 on 5/22/25 at 11:47 AM revealed the day of the fall she was in the room changing Resident #1 by herself. She explained that after she turned the resident onto her left side, she reached back to get a diaper and wipes, and the resident was reaching for the bedside table and rolled away for her. She explained that she tried to grab onto the resident's gown but could not stop her from falling. She stated that the resident fell on to the floor and looked up at her and stated, I'm sorry, I rolled away. She stated at that time the resident was one or two-person assistance with care. An interview with LPN #1 on 5/22/25 at 1:01 PM revealed Resident #1 did have one-half (1/2) side rails that she used for assistance with turning and revealed they were removed. She confirmed that the resident would utilize the 1/2 rail to hold onto when turning. She explained we were told they must be removed because of the state regulations that bed rails were restraints. She stated, That was what I was told. She confirmed she was not aware of any other safety interventions put into place after the bedrails were removed. Record review of Resident #1's Order Summary Report revealed an order dated 8/28/24, Pressure redistribution mattress to bed every shift. An interview with the Director of Nursing (DON) on 5/22/25 at 2:10 PM revealed Resident #1 did have the side rails, and they were later removed due to policy changes made by corporate to remove all the side rails. She explained that she did not know the exact date they were removed but revealed it had been a while. She confirmed a side rail assessment was not completed on Resident #1 when they were removed and confirmed it should have been completed to evaluate whether it was safe for the resident to be without them. She confirmed no other measures were put into place after bed rail removal to prevent injury. She acknowledged that she could see how an air mattress could shift and cause the resident to fall off the bed if someone or something was not there to provide the proper support. Review of the Admission Record revealed the facility admitted Resident #1 on 3/01/23 with a medical diagnosis that included but was not limited to Chronic Obstructive Pulmonary Disease, Muscle Wasting and Atrophy, Repeated Falls, and Need for Assistance with Personal Care. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/24/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #1 was moderately cognitively impaired.