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	11/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interview, the facility failed to notify the provider to clarify missing orders for previously established interventions following a resident's return from the hospital. This resulted in a lapse in continuity of care for one (1) of three (3) residents reviewed for hospital readmission. Resident # 1.Findings Include: Record review of July 2025 Order Summary Report for Resident #1 revealed an abduction pillow, and nutritional supplement was ordered prior to hospital transfer on 8/15/25. Review of the After Visit Summary dated 8/18/2025 showed no mention of these interventions. Upon readmission, the facility did not contact the provider to clarify whether the interventions should be resumed, and the interventions were not reinstated. During an interview on11/6/25 at 8:15 AM, with the Assistant Director of Nursing (ADON) she stated the facility only re-enters what the hospital sends back after clarification with the provider. She verified they did not seek clarification about pre-hospital interventions of the abduction pillow or nutritional supplement.In an interview on 11/6/25 at 9:00 AM, the Director of Nursing (DON) confirmed the provider was not notified to clarify the missing orders, but they should have.During an interview with the Administrator on 11/6/25 at 9:30 AM, he verified that the facility did not have a policy regarding transcribing readmission orders or reviewing previously established interventions prior to determine if they should be continued.During a telephone interview with Nurse Practitioner #2 (NP) on 11/6/25 at 10:00 AM, she verified that she, nor the on-call NP were contacted to clarify if the interventions should be continued and they should have been. Record review of admission Record revealed the facility admitted Resident #1 on 11/6/2019 with diagnoses of Malignant Neoplasm or Cervix Uteri, Protein-Calorie Malnutrition, Vitamin D Deficiency, and Bilateral Femoral Neck Fractures. Record review of Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/09/2025 revealed a Brief Interview for Mental Status (BIMS) score of one (1) indicating Resident #1 is cognitively impaired. Section GG Functional Abilities indicated that Resident #1 is dependent for transfers and does not ambulate.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, record review and facility policy review the facility failed to report an injury of unknown origin to the State Agency (SA) as required for one (1) of three (3) residents reviewed for injuries. Resident #1.Findings Include:Record review of the facility's policy titled Abuse Prohibition Policy revealed: The Abuse Coordinator will report such allegations to the state agency in accordance with the state law .The Abuse Coordinator will report .injuries of unknown source with serious bodily injury within two (2) hours of the allegation. Review of the facility's investigation, provided by the Administrator (ADM), revealed that on 5/28/25, Resident #1 experienced a syncopal episode and was transferred to the emergency room (ER). The Responsible Party (RP) later informed the facility that when Emergency Medical Services (EMS) transferred the resident from bed to stretcher on 5/28/25, the resident yelled out in pain and that EMS was not gentle. The investigation file included no documentation of staff witness statements, no record of conversation with the RP prior to the injury, and no supporting documentation verifying the conclusion that the fractures were pathological. The facility's investigative summary cited possible causes-pathological process, seizure activity, or rough EMS transfer.Record review of the Computerized Tomography (CT) of pelvis dated 7/4/25, for Resident #1, revealed bilateral displaced femoral neck fractures which may be subacute in nature given area of callus formation.During an interview with the Administrator (ADM) on 11/5/25 at 11:00 AM, he stated the investigation was initiated on 7/3/25 when the fractures were identified. The ADM stated the fractures were not reported to the State Agency because the facility believed they were pathological, but he agreed that the cause of the fractures could not be determined and therefore met the definition of injuries of unknown origin that should have been reported. The ADM confirmed that the RP shared with them that the EMS had been rough with the resident during transport on 05/28/25 so that is why the investigation was dated for that day. During an interview with the Director of Nursing (DON) on 11/5/25 at 9:30 AM, she verified that Resident #1 was sent to the hospital on 7/3/25 for evaluation of seizure-like activity, where imaging revealed bilateral femur fractures. She stated that the facility looked into it but was unable to determine the cause of the fractures.Record review of a Nurse's Note dated 07/02/25 revealed, Nurse Practitioner (NP) notified of bruising to face. Record review of admission Record revealed the facility admitted Resident #1 on 11/6/2019 with diagnoses of Malignant Neoplasm or Cervix Uteri, Protein-Calorie Malnutrition, and Vitamin D Deficiency. Record review of Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/09/2025 revealed a Brief Interview for Mental Status (BIMS) score of one (1) indicating Resident #1 is cognitively impaired. Section GG Functional Abilities indicated that Resident #1 is dependent for transfers and does not ambulate.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interview record review, and facility policy review the facility failed to conduct a prompt and thorough investigation of an injury of unknown origin to determine whether abuse, neglect, or a clinical cause contributed to the injury for one (1) of three (3) residents reviewed for injuries. Resident #1.Findings Included: Record review of the facility's policy titled Abuse Prohibition Policy revealed: Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions. 5. Investigations will be prompt, comprehensive, and responsive to the situation and contain founded conclusions.Review of the facility's investigation, provided by the Administrator (ADM), revealed that on 5/28/25, Resident #1 experienced a syncopal episode and was transferred to the emergency room (ER). The Responsible Party (RP) later informed the facility that when Emergency Medical Services (EMS) transferred the resident from bed to stretcher on 5/28/25, the resident yelled out in pain and that EMS was not gentle. The investigation file included no documentation of staff witness statements, no record of conversation with the RP prior to the injury, and no supporting documentation verifying the conclusion that the fractures were pathological. The facility's investigative summary cited possible causes-pathological process, seizure activity, or rough EMS transfer.The facility's investigation was dated 5/28/25, though the injury was not identified until 7/3/25, when the resident was sent to the ER for evaluation of possible transient ischemic attack (TIA) and was found to have bilateral femoral neck fractures.In an investigation with the Administrator on 11/5/25 at 11:00 AM, he stated the investigation was initiated on 7/3/25 when the fractures were identified, but the investigation form was dated 5/28/25 because that was the date of the EMS transferring the resident roughly. He stated that this incident was not previously reported by the RP when it occurred on 05/28/25 and because they didn't know a cause of the fractures, the RP had referred to the event and wondered if that is when the fractures occurred. The ADM verified that staff were not asked to provide written statements confirming whether any incidents occurred and acknowledged that there was no information in the investigation regarding events leading to the 7/3/25 hospital transfer, the resident's seizure activity, or current hospital documentation. The ADM stated the fractures should have been fully investigated.Record review of Resident #1's Progress Notes dated 7/2/25, revealed the Nurse Practitioner was notified of bruising to the resident's face without a reported history of trauma.Record review of the Computerized Tomography (CT) of pelvis dated 7/4/25, for Resident #1, revealed bilateral displaced femoral neck fractures which may be subacute in nature given area of callus formation.On 11/5/25 at 9:30 AM, the during an interview with the Director of Nursing (DON) verified that Resident #1 was sent to the hospital on 7/3/25 for evaluation of seizure-like activity, where imaging revealed bilateral femur fractures. She stated that the facility looked into it but was unable to determine the cause of the fractures.Record review of a Progress Note dated 07/08/25 stated, Follow up with daughter after investigation next week. Record review of Car Plan Meeting notes dated 07/15/25 stated, ADM will reach out next week after investigation is completed.In a telephone interview with the Responsible Party (RP) on 11/05/25 at 9:00 AM, she stated that the facility would not tell her anything about what caused her mother's leg fractures or her black eye. She further stated that during the care plan meeting, that she had requested, the Director of Nursing (DON) and Administrator said that it could have been caused by the EMT during her transfer. Record review of admission Record revealed the facility admitted Resident #1 on 11/6/2019 with diagnoses of Malignant Neoplasm or Cervix Uteri, Protein-Calorie Malnutrition, and Vitamin D Deficiency. Record review of Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/09/2025 revealed a Brief Interview for Mental Status (BIMS) score of one (1) indicating Resident #1 is cognitively impaired. Section GG Functional Abilities indicated that Resident #1 is dependent for transfers and does not ambulate.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure a complete and accurate medical record was maintained when a verified exercise order was not entered into the electronic medical record, resulting in an incomplete clinical record for one (1) of three (3) sampled residents reviewed for medical record accuracy .Resident #1.Findings Included: Record review of a Return to Work/School form provided by the Orthopedic Physician's office for Resident #1 revealed and order, dated 7/18/25, for work on passive exercises for lower extremity due to patient non weight bearing status for 1-2 times a week. Work on active range of motion for upper extremity to ensure tone and minimalize stiffness for 1-2 times a week. The form was initialized and dated 7/22/25. Review of Resident #1's physician orders for July 2025 revealed no documentation that the new exercises were ordered. As a result, the services were not initiated as ordered. During an interview on 11/5/25 at 12:00 PM, the Director of Nursing (DON) stated that the nurse practitioner (NP) verified the order for therapy but did not enter it into the system. She stated that the NPs are responsible for putting their own orders in the computer. The DON agreed that the resident's medical record did not accurately reflect all current physician and NP orders. During a telephone interview with Nurse Practitioner #1 (NP) on 11/5/25 at 1:01 PM, she verified that she reviewed and signed off on the orders but failed to enter them into the computer.Interview with the Administrator (ADM) on 11/5/25 at 2:00 PM, he verified that the facility did not have a policy for transcribing orders into the computer system.Record review of admission Record revealed the facility admitted Resident #1 on 11/6/2019 with diagnoses of Malignant Neoplasm or Cervix Uteri, Protein-Calorie Malnutrition, and Vitamin D Deficiency, and Fracture of the Neck of the Left and Right Femur. Record review of Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/09/2025 revealed a Brief Interview for Mental Status (BIMS) score of one (1) indicating Resident #1 is cognitively impaired. Section GG Functional Abilities indicated that Resident #1 is dependent for transfers and does not ambulate.