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	255269	A. BUILDING _____ B. WING _____	09/05/2024

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 9/3/24 through 9/5/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and deficiencies were cited at F558, F584, F656, and F677. The census at the time of survey was 90 and the facility was licensed for 120 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to ensure a resident had a properly fitting wheelchair for one (1) of 20 sampled residents. Resident #83 Findings Include: Record review of a typed statement on facility letterhead and signed by the Administrator, revealed "This facility does not have a policy related to resident equipment, including wheelchairs." An observation and interview on 9/3/2024 at 11:20 AM, with Resident #83 revealed, she was sitting in a wheelchair in her room. The resident's	F 558	Resident # 83□s wheelchair was replaced with a properly fitting wheelchair on September 4, 2024, by the Director of Rehab. The facility determined that all residents who require a wheelchair have the potential to be affected. The nursing and therapy staff were in-serviced by the Staff Development Nurse on properly fitting wheelchairs. The in-service began on September 4, 2024, and was completed on September 23, 2024. On September 4, 2024 the Director of Rehab did a 100% wheelchair fit check	10/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/20/2024

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F 558	Continued From page 1 feet were dangling down of the seat of the wheelchair and did not touch the floor. The resident revealed she propelled herself throughout the facility in the wheelchair and admitted it was difficult to do this because her feet did not touch the floor. An interview with Certified Nurse Aide (CNA) #2 on 9/4/2024 at 11:05 AM, confirmed Resident #83 used her wheelchair to propel herself about the facility and this was her method of mobility. An interview with Resident #83, on 9/4/2024 at 11:40 AM, revealed she would like a better fitting wheelchair so that her feet could touch the floor and it would be more comfortable. An observation and interview, on 9/4/2024 at 11:45 AM, with Registered Nurse (RN) # 2, confirmed Resident #83's wheelchair was too tall for her and acknowledged the resident would have trouble with foot propulsion since her feet did not contact the floor. An interview with the Occupational Therapist (OT) on 9/4/2024 at 11:54 AM revealed, when a resident admits to the facility, someone usually goes and gets an available wheelchair from inside the facility. He revealed the wheelchair was not customized to fit Resident #83 and stated her feet should reach the floor to safely self-propel. An interview with the Administrator on 9/4/2024 at 1:50 PM, confirmed Resident #83 should have a proper fitting wheelchair to meet the resident's needs. Review of the "Admission Record" revealed the facility admitted Resident #83 on 8/1/2024 with	F 558	on all residents requiring a wheelchair. All new admissions requiring a wheelchair will be evaluated by a therapist for proper fitting. The Quality Assurance Nurse will complete five wheelchair audits which began the week of September 9, 2024, to ensure residents have proper fitting wheelchairs. These audits will be conducted two times per week for four weeks and then one time per week for four weeks. The Quality Assurance Nurse will report any issues identified to the Director of Nursing for correction, who will bring all findings to the Quality Assurance Committee October 4, 2024, for review and recommendations. The Director of Nursing will continue to bring findings from the audits to the Quality Assurance Committee monthly for two months.	

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F 558	Continued From page 2 medical diagnoses that included Unspecified fracture of the left femur. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/9/2024 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicates Resident #83 was cognitively intact.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		10/5/24

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F 584	Continued From page 3 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure the residents rooms were clean and in good repair for three (3) of 90 resident's rooms observed during survey. Resident #12, #17 and #28. Findings Include: Review of the facility policy titled, "Room and Restroom Daily Cleaning Duties " with a revision date of 4/9/2020 revealed " ...Procedure ...7. The third rag should be used to clean the bed. Wipe down all bed rails, head and foot boards ..." Review of the facility policy titled, "Resident Room and Bathroom Complete/Deep Cleaning Policy" with no revision date, revealed, "It is the policy of "Proper Name" Services to "Complete/Deep Clean" all resident rooms on a monthly basis...Procedure...2. Beds ...Headboards and rails will be included ... 6. Cubicle Curtain ...each cubicle curtain will be checked for cleaning. If needed, it will be replaced, and the old one will be	F 584	Housekeeping manager replaced resident #12's privacy curtain on September 3, 2024. Maintenance director repaired resident #17's closet door on September 3, 2024. Unit manager cleaned resident #28's bedrails on September 4, 2024. The facility determined that all residents have the potential to be affected. The nursing and housekeeping staff were in-serviced by the Staff Development Nurse on properly cleaning of resident's rooms on September 4, 2024. Maintenance director was in-serviced by Administrator on timely repairs on September 3, 2024. Department heads were in serviced by Director of Nursing on reporting maintenance needs on September 4, 2024. Beginning September 4, 2024, administrative staff were assigned	

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F 584	Continued From page 4 washed in the laundry ..." Record review of a typed statement on facility letterhead, undated and signed by the Administrator revealed "This facility does not have a policy related to environmental cleaning. Resident #12 An observation on 9/3/24 at 11:12 AM, of Resident #12's room revealed, the privacy curtain at the foot of the resident's bed had approximately 8 brown stains about 1-2 inches wide scattered over the curtain. Review of Resident #12's "Admission Record" revealed the resident was admitted to the facility on 5/11/22 with medical diagnoses that include Cerebral Infarction. Review of Resident #12's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/24 revealed in section C, a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #17 An observation and interview on 9/3/24 at 2:38 PM, with Resident #17 revealed, her closet door on one side had been broken for a long time and maintenance knew about it. She stated "the nurses and aides must get my clothes out of the closet daily, so they see that only one side works." This observation revealed the resident's closet had double sliding doors and one door was off the track and propped against the clothes that were hung in the closet.	F 584	occupied rooms for room rounds to ensure cleanliness and that there are no repairs needed.These audits will be conducted three times per week for four weeks, two times per week for four weeks, and 1 time per week for four weeks. The administrative staff will report any issues identified to the Director of Nursing for correction, who will bring all findings to the Quality Assurance Committee on October 4, 2024. This plan of correction will be discussed at the monthly Quality Assurance meetings at minimum for the next two months.	

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F 584	Continued From page 5	F 584		

Review of Resident #17's "Admission Record" revealed the resident was admitted to the facility on 7/17/13 with medical diagnoses that included Multiple Sclerosis.

Review of Resident 17's MDS with an ARD of 6/18/24 revealed in section C, a BIMS score of 15, which indicated the resident was cognitively intact.

Review of the "List of Rooms to be done by Maintenance" did not include Resident #17's room.

An interview on 9/3/24 at 2:45 PM, with Licensed Practical Nurse (LPN) #2 revealed, they do "Angel Rounds" at the beginning of their shifts. She revealed these rounds were done to make sure the rooms were clean and there were no repairs needed in each room.

An interview on 9/4/24 at 8:41 AM, with LPN #1, revealed all office nurses have assigned rooms that they make "Angel Rounds" on one time per week. She revealed they make these rounds to make sure the rooms were clean and there were not any needed repairs. She stated if they find something that maintenance needs to repair then they just call him.

A review of the schedule for "Angel Rounds" revealed that all resident rooms were assigned to an administrative nurse.

An interview on 9/4/24 at 10:21 AM, with the Maintenance Director confirmed that staff usually send him a text or a group email when repairs need to be made. He confirmed there was a

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F 584	Continued From page 6	F 584		

maintenance log at the nurse's desk, but text and email were the best communication. He revealed the list of rooms that needed to be repaired was on the list that he provided and that was all the repairs that he was aware of.

An interview and observation on 9/4/24 at 10:48 AM, with the Administrator, confirmed Resident #17's closet door was off track and should have been found on the "Angel Rounds" and maintenance should have been notified to keep the resident's room in good repair. The Administrator confirmed Resident #12's dirty privacy curtain. The Administrator acknowledged the privacy curtain needed to be changed out because it was dirty.

An interview on 9/4/24 at 2:28 PM, with Housekeeping #2 revealed, that if she found a dirty privacy curtain, she would notify her supervisor and she would resolve it.

An interview on 9/4/24 at 3:10 PM, with the District Manager for Housekeeping confirmed that if a housekeeper noticed that a privacy curtain was dirty then they can replace it. She said the rooms get deep cleaned one time monthly and curtains also get replaced then if they are dirty.

Review of the Monthly Calendar for Deep Cleaning resident rooms revealed that Resident #12's room was due for a deep cleaning on 8/29/24 and Resident #28's room was due on 8/30/24.

Resident #28

An observation on 9/3/24 at 11:35 AM, revealed dirty bilateral one-quarter length bed rails in

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F 584	Continued From page 7	F 584		

Resident #28's room. The right bed rail had three areas approximately one inch long by one-quarter inch wide of brownish yellow substance on the interior part next to the mattress. The left bed rail had two areas of brown substance approximately one inch by one-half inch on the inner left bed rail and had a gray substance scattered along the entire length of the top bar of the quarter-sized bed rail.

An observation on 9/4/24 at 7:38 AM, of Resident #28's room, revealed the right interior bed rail with brownish yellow substance scattered in three places approximately one inch by one-quarter inch. The left bed rail had two areas of brown substance approximately one inch by one-half inch on the inner left bed rail and had a grayish substance along the entire top edge of the quarter-sized bed rail.

An interview on 9/4/24 at 11:18 AM, with District Housekeeping Supervisor, revealed that they cleaned resident rooms every day and that the staff deep cleaned the rooms once a month. She revealed that the daily resident room cleaning included spot checking the walls, cleaning the bathrooms, sweeping, mopping, and wiping down all high contact surfaces. She confirmed that cleaning the bed rails was part of the daily cleaning tasks and stated "It is our responsibility." The District Housekeeping Supervisor revealed that the young ladies in housekeeping were new, and she was working on retraining them on things she had noticed that they needed to improve on. She also revealed that she would make sure the bed rails were cleaned from now on.

An interview on 9/4/24 at 10:20 AM, with Registered Nurse (RN) Unit Manager confirmed

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F 584	Continued From page 8 that Resident #28's bedrails had the brownish yellow substance and the grayish substance on both bilateral rails. She revealed that dirty side rails could cause the spread of germs and stated, "I will get them cleaned right now." The RN Unit Manager also revealed that it was everyone's responsibility to clean the side rails if they noticed them to be dirty. An interview on 9/4/24 at 10:25 AM, with Licensed Practical Nurse (LPN) #3, revealed that the Housekeeping Department was responsible for cleaning the bed rails. She observed and confirmed that Resident #28's bilateral side rails were dirty and stated, " We don't know what it is." Record review of Resident #28's "Admission Record" revealed an admission date of 6/17/2024 and diagnoses that included Need for assistance with personal care, Cerebral infarction, and Anxiety disorder. Record review of Resident #28's MDS with ARD of 6/24/2024 revealed under section C, a BIMS score of 10 which indicates Resident #28 had moderate cognitive deficits.	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		10/5/24

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F 656	Continued From page 9	F 656		

assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, record review, and facility policy review, the facility failed

Certified Nurse Aide #1 changed resident # 31□s soiled shirt on September 4, 2024.

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F 656	Continued From page 10 to implement a comprehensive care plan related to personal hygiene for one (1) of 20 sampled residents. Resident #31. Findings Included: Review of the facility policy titled, "Comprehensive Plan of Care," dated 10/10/22 revealed " Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...." Record review of Resident #31's Care Plan with a date initiated 2/27/24 revealed "Focus: Resident requires staff assistance with ADL's (Activities of Daily Living) related to Dysphagia and History of CVA (Cerebrovascular Accident) with left sided hemiparesis. Goal: ...will be provided with ADL's according to daily needs through next review ..." On 9/3/24 at 10:34 AM, an observation revealed Resident #31 lying in his bed and he wearing a short-sleeved shirt. The resident's shirt had an area of white, crusty substance on the right anterior sleeve and a quarter-sized, dried, brown substance on the upper, anterior chest area of the shirt. On 9/3/24 at 11:50 AM, an observation revealed Resident #31 lying in his bed and he had the same short-sleeved shirt on with the dried substance. On 9/4/24 at 7:40 AM, an observation revealed Resident #31 lying on his left side in his bed with the same short-sleeved T-shirt he had on the day before on 09/03/24. On 9/4/24 at 3:06 PM, an observation and	F 656	All nursing staff were in-serviced by the Staff Development nurse on September 4, 2024, to follow the Activities of Daily Living care plan when providing resident care. The facility determined that all residents have the potential to be affected. The Staff Development Nurse in-serviced all Certified Nursing Aides on following the Activities Daily Living care plan. The in-service began on September 4, 2024, and will be completed on September 23, 2024. The Quality Assurance nurse began audits the week of September 9, 2024, to ensure residents are dressed in clean clothing. These audits will include five residents three times per week for four weeks, five residents two times a week for four weeks and five residents one time per week for four weeks.The Quality Assurance Nurse will report any issues identified to the Director of Nursing for correction, who will bring all findings to the Quality Assurance Committee on October 4, 2024, for review and recommendations. The Director of Nursing will continue to bring findings from the audits to the Quality Assurance Committee monthly for two months.	

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F 656	Continued From page 11 interview with Certified Nursing Assistant (CNA) #1, revealed that Resident #31 was assigned to her today. She confirmed it is in his care plan to receive hygiene care. On 9/4/24 at 3:40 PM, an interview with Minimum Data Set (MDS) Coordinator, revealed that the comprehensive care plan was developed to provide patient-centered, individualized care for each resident. MDS Coordinator agreed that Resident #31's care plan was not followed when the staff failed to assist him with his ADL needs. Record review of Resident #31's "Admission Record" revealed an admit date of 01/21/2021 with diagnoses that included Need for Assistance with Personal Care, Cerebral Infarction with Hemiplegia and Hemiparesis affecting left non-dominant side. Record review of Resident #31's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/26/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that he had severe cognitive deficits.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for	F 677	Certified Nurse Aide #1 changed resident #31's soiled shirt on September 4, 2024. The staff development nurse in-serviced	10/5/24

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OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12 a resident dependent on staff for care for one (1) of 20 sampled residents. Resident #31 Findings Included: Review of the facility policy, "Activities of Daily Living (ADL)" with revised date of 09/15/2022 revealed , "Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care....." An observation on 9/03/24 at 10:34 AM, revealed Resident #31 lying in his bed and he wore a red short-sleeved T-shirt. Resident #31's shirt had an area of white, crusty substance on the right anterior sleeve and also a quarter-sized area of dried, brown substance on the upper center front of the shirt. An observation on 09/03/24 at 11:50 AM, revealed Resident #31 lying in his bed and he had the same red short-sleeved shirt on. An observation on 09/04/24 at 7:40 AM, revealed Resident #31 lying on his left side in his bed with the same red short-sleeved shirt he had on the day before on 09/03/24. An observation and interview on 09/04/24 at 3:06 PM, with Certified Nursing Assistant (CNA) #1, revealed that Resident #31 was assigned to her today. She revealed that this resident was on hospice services, and their CNAs came to the facility three times a week to bathe him. CNA #1 revealed that Resident #31 was on a pureed diet and would often drop food on his clothes or in his beard. She revealed that on the days that hospice didn't come, the facility CNAs were responsible for changing the residents' clothes and bathing	F 677	all nursing staff on September 4, 2024, to follow the Activity of Daily Living care plan when providing resident care. The facility has determined that all residents requiring assistance with ADL care have the potential to be affected. On September 4, 2024, the unit managers completed a 100% audit on all residents for soiled clothing. Soiled clothing was removed as residents allowed at the time of observation. All certified nursing staff were in-serviced by the Staff Development Nurse on ADL care. The in-service began on September 4, 2024, and will be completed on Monday September 23, 2024. The Quality Assurance nurse began audits the week of September 9, 2024, to ensure residents are dressed in clean clothing. These audits will include five residents three times per week for four weeks, five residents two times a week for four weeks and five residents one time per week for four weeks. The Quality Assurance Nurse will report any issues identified to the Director of Nursing for correction, who will bring all findings to the Quality Assurance Committee on October 4, 2024, for review and recommendations. The Director of Nursing will continue to bring findings from the audits to the Quality Assurance Committee monthly for two months.	

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 _____	09/05/2024

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F 677	Continued From page 13	F 677		

them if needed. CNA #1 confirmed the dried white and brown substance on Resident #31's red shirt and stated, "It looks like food." She revealed that she had been in and out of his room and had not noticed his dirty shirt and that she would change his clothes now.

On 09/04/24 at 3:10 PM, an interview with Licensed Practical Nurse (LPN) #3 revealed that Resident #31 was assigned to her today and she had been in and out of his room all day. She revealed that she had not noticed that he had on the same shirt as yesterday or that it was dirty. LPN #3 revealed that she should have paid more attention to him and not been in a hurry and stated, "There's no excuse for this." LPN #3 revealed that resident care was supposed to be the same whether hospice staff came in or not and stated, "This falls on us, we should have already changed him." She also revealed that residents' clothes should be changed every day whether they were scheduled to have a bath or not. LPN #3 revealed that this facility was their home and stated, "These residents should be treated like we want to be treated and we get to change our clothes every day."

An interview on 09/04/24 at 3:25 PM, with Registered Nurse (RN) Unit Manager, revealed that she failed to check the shower book this morning to make sure that Resident #31 received his ADL care. She revealed that she fed Resident #31 earlier, had put a clothing protector on him, and had not noticed the dirty shirt he had on.

Record review of Resident #31's "Admission Record" revealed an admit date of 01/21/2021 and that he had diagnoses that included Need for Assistance with Personal Care, Cerebral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 14 Infarction with Hemiplegia and Hemiparesis affecting his left non-dominant side. Record review of Resident #31's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/26/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that he had severe cognitive deficits.	F 677		