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GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 6/23/25 through 6/25/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M500, M640, and M655. The census at the time of survey was 50 and the facility held a license for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		7/21/25

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and	M 500	1. On 6/30/2025, residents # 8, 13, 21, and 23 had an updated psychoactive medication consent form completed with risk versus benefits included. Risk versus benefits were explained to each resident	

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M 500	Continued From page 4 facility policy review, the facility failed to notify a resident and/or a legal representative of the risks and benefits of using a psychotropic medication for four (4) of 42 residents reviewed for psychotropic drug use. Resident #8, #13, #21, and #23 Findings Include: Review of the facility policy titled "Psychotropic/Psychoactive Medication Policy" with a revision date of 6/24/25 revealed under, "Policy Implementation: ... 5. All residents have full rights to participate or refuse treatment. Before initiating or increasing psychotropic medication the resident and or responsible party must be notified of and have the right to participate in their treatment, including the right to accept or decline the medication. The risk and benefits should be clearly explained..." Resident #8 Record review of Resident #8's "Order Summary Listing" revealed the following orders: - Dated 3/06/25: "Buspirone HCL (hydrochloride) oral tablet 5 MG (milligrams) give 1 (one) tablet by mouth three times a day for anxiety; Xanax oral tablet 0.5 MG (milligram) give 1 (one) tablet by mouth at bedtime for anxiety, hold for sedation." - Dated 5/08/25: "Cymbalta oral capsule delayed-release 30 MG give 1 capsule by mouth in the morning for depression." Record review of Resident #8's "Psychoactive Medication Informed Consent" dated 6/20/24 revealed there was no documentation that the risks and benefits were discussed with the resident or their representative when the	M 500	responsible party by the Social Services Director (SSD). 2. All residents who receive psychoactive medications have the ability to be affected by the deficient practice. 3. On 6/25/2025, the SSD was in-serviced by the facility Administrator to ensure risk versus benefits is discussed with the responsible party prior to obtaining consent. The facility implemented an updated psychoactive medication consent form which lists risk based on the drug classification. 4. Beginning 6/30/2025, the Administrator or Director of Nursing (DON) will conduct audits on five (5) residents that are on psychoactive medications to ensure that consent forms have risk versus benefits 5 times a week for four (4) weeks, then three (3) times a week for 4 weeks, then weekly for 3 months. The results of the audit will be brought to the monthly Quality Assurance (QA) meeting by the Administrator or DON for review and discussion beginning 7/21/2025. The QA meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial QA meeting was held on 6/27/2025 to discuss and implement the plan of correction.	

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medication was initiated.

Record review of the "Admission Record" revealed Resident #8 was admitted on 5/12/23 with medical diagnoses including Major Depressive Disorder and Anxiety Disorder.

Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/15/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.

Resident #13

Record review of the "Order Summary Report" for Resident #13 revealed the following orders:
- Dated 1/06/25: "Buspirone HCL oral tablet 15 MG give 1 tablet by mouth three times a day for anxiety; Quetiapine Fumarate oral tablet 25 MG give 3 (three) tablets by mouth three times a day for antipsychotic use."
- Dated 6/12/25: "Lorazepam oral tablet 0.5 MG give 1 tablet by mouth every 12 (twelve) hours as needed for anxiety and agitation for 14 days until 6/26/25."

Review of Resident #13's "Psychoactive Medication Informed Consent" dated 7/24/24 revealed there was no documentation that the risks and benefits were discussed with the resident representative when the medication was initiated.

Record review of the "Admission Record" revealed Resident #13 was admitted on 7/09/24 with medical diagnoses including Unspecified Dementia, Major Depressive Disorder, and Anxiety Disorder.

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Record review of the MDS with an ARD of 4/14/25 revealed, under section C, Resident #13's cognitive skills for daily decision-making were severely impaired.

Resident #23

Record review of the "Order Listing Summary" for Resident #23 revealed the following orders:
- Dated 3/19/25: "Diazepam oral tablet 5 MG give 1 tablet by mouth in the evening for anxiety."
- Dated 4/29/25: "Olanzapine oral tablet 5 MG give 0.5 (one-half) tablet by mouth at bedtime for psychosis."
- Dated 5/15/25: "Zoloft oral tablet 50 MG give 3 (three) tablets by mouth at bedtime for mood total 150 MG."

Review of Resident #23's "Psychoactive Medication Informed Consent" dated 11/5/24 revealed there was no documentation that the risks and benefits were discussed with the resident representative when the medication was initiated.

Review of the "Admission Record" revealed Resident #23 was admitted on 11/01/24 with medical diagnoses including Dementia with Mood Disturbance, Unspecified Psychosis, and Major Depressive Disorder.

Review of the MDS with an ARD of 5/07/25 revealed a BIMS score of 7, indicating severe cognitive impairment.

An interview with Social Services (SS) #1 on 6/24/25 at 1:05 PM revealed she was responsible for calling families to obtain psychotropic consents. She confirmed she did not discuss the risks and benefits of the medications with the

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residents or families of Resident #8, #13, #21, and #23. SS #1 stated she did not have a pharmacological (pertaining to medication) background and acknowledged residents and families should be fully informed before consenting to treatment.

An interview with the Director of Nursing (DON) on 6/24/25 at 1:24 PM confirmed she was aware that the risks and benefits of psychotropic medications were not being discussed with the families or the residents. She stated that social services was responsible for obtaining consents and acknowledged that this information must be provided for informed decision-making and consent.

Resident #21

Record review of Resident #21's "Order Summary Listing" revealed an order dated 11/14/24, "Lorazepam oral tablet 0.5 MG give 1 tablet by mouth two times a day for anxiety and agitation."

Record review of Resident #21's "Order Summary Listing" revealed an order dated 2/18/25, "Seroquel oral tablet 100 MG give 1 tablet by mouth three times a day for psychosis, delusions."

Record review of Resident #21's "Order Summary Listing" revealed an order dated 6/5/25, "Zoloft oral tablet 50 MG give 1 tablet by mouth in the morning for Major Depressive Disorder."

Record review of Resident #21's "Psychoactive Consent" dated 6/20/24, revealed no documentation of the risks and benefits was provided to the resident or the resident

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M 500	Continued From page 8 representative (RR) when the medication was initiated. A record review of the "Admission Record" indicated the facility admitted Resident #21 to the facility on 4/25/22 with medical diagnosis of Major Depressive Disorder. Record review of the MDS with an ARD of 6/3/2025 revealed under section C, a BIMS score of 15, which indicated the resident was cognitively intact.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, and record review, the facility failed to ensure a safe environment by not preventing hazardous substances from being stored in a resident's room, thereby creating the potential for accidental ingestion and harm. Specifically, the facility failed to prevent a resident's family from placing two homemade containers of ant bait (containing boric acid) in the resident ' s room, which remained accessible to Resident #15 and potentially to other cognitively impaired, wandering residents. This deficient practice affected one (1) of fifty (50) residents reviewed	M 640	1. On 6/23/2025, the homemade ant bait was removed from resident # 15's room. On 6/23/2025, the family of resident # 15 was notified by the Administrator that the resident could not have hazardous materials left in the room. Resident # 15 was assessed with no negative findings. The facility Administrator and Maintenance Director completed a facility wide audit on 6/23/2025 to identify any other hazardous material with no other materials identified. 2. All residents whose family leaves unattended hazardous materials in the room can be affected by the deficient	7/21/25

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M 640	Continued From page 9 (Resident #15). Findings Include: Review of the typed statement on facility letterhead revealed the facility did not have a policy regarding storing hazardous materials in residents rooms and was signed by the Administrator. During an observation and interview in Resident #15's room on 6/23/25 at 12:00 PM with Licensed Practical Nurse (LPN) #1, she confirmed the presence of two (2) four-ounce, white, round, wide-mouth plastic jars, each with a matching white screw-on lid featuring a pencil-sized hole in the center of the lid. The words "Ant Bait" were written on the side of the jars in marker. Additionally, the ingredients were listed as follows: honey, water, and boric acid. The LPN stated that these items were apparently brought in by the family but should not have been left in the room, as they pose a danger to confused, wandering residents. She further expressed that if anyone were to ingest this mixture, "a lot of bad things could happen." The LPN disposed of the containers. During an interview on 6/24/25 at 9:40 AM with the Director of Nursing (DON), she confirmed that such homemade insect repellant/bait should not be left in the rooms. She stated, "We want them to feel that this is their home, but we have to stay within the guidelines and keep all other residents safe at the same time." She further verified that if another resident had ingested the contents, it could have been dangerous for them. A record review of the "Admission Record" for Resident #15 revealed that she was admitted to	M 640	practice as well as any cognitively impaired residents that wander. 3. On 6/25/2025, the facility Staff Development Coordinator (SDC) initiated in-services with all staff regarding storing hazardous material in residents' rooms which is not allowed and notifying the Director of Nursing or Administrator if any such material is found in a resident's room. On 7/2/2025, the Administrator mailed letters to each resident responsible party informing them that hazardous materials can't be left in a resident's room. 4. Beginning 6/30/2025, the facility SDC or Administrator will perform visual room check audits on each room to ensure there are no hazardous materials in the room five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for three (3) months. The facility SDC or Administrator will bring the results of the audits to the monthly Quality Assurance (QA) meeting for review and discussion beginning 7/21/2025. The QA meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial QA meeting was held on 6/27/2025 to discuss and implement the plan of correction.	

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M 640	Continued From page 10 the facility on 5/14/25 with medical diagnoses that included Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Heart Failure, Unspecified, and Cerebral Aneurysm, Non-ruptured. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/21/2025, revealed Resident #15 did not have a Brief Interview for Mental Status (BIMS) because the resident is rarely/never understood. Staff Assessment for Mental Status revealed the resident had a problem with short-term and long-term memory.	M 640		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure that an indwelling urinary catheter was clinically indicated and ordered by the provider for one (1) of three (3) residents reviewed with catheters (Resident #105). Findings include:	M 655	1. On 6/24/2025, the facility Medical Director was notified that resident # 105 was admitted to the facility with no orders or directions from the referring hospital regarding a Foley catheter and an order obtained to leave the Foley catheter in place and consult urology. On 6/24/2025, the Director of Nursing (DON) completed an audit on all residents with a foley catheter present. 2. Any resident who admitted to the	7/21/25

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M 655	Continued From page 11 Review of the facility policy titled, "Indwelling (Foley) Catheter Insertion, Male Resident," revised March 2024, revealed "Preparation: 2.) Verify that there is a physician's order..." An observation on 6/23/25 at 10:00 AM revealed Resident #105 had an indwelling urinary catheter. A continued interview with the resident revealed he stated that they put the catheter in him while in the hospital and never took it out, but confirmed he did not know why he had it. During an interview with Registered Nurse (RN) #1 on 6/24/25 at 9:00 AM, she revealed after review of the hospital "After Visit Summary" for Resident #105 that there was no mention of the resident having a catheter order. She stated that it is not uncommon for a resident to be admitted to the facility with a catheter and no orders. She stated the nurse that admitted the resident should have notified the provider to obtain orders to keep the catheter, discontinue it, or obtain a urology referral. She also stated that keeping the catheter in without an appropriate diagnosis places the resident at increased risk of infections. Record review of the "After Visit Summary" for Resident #105 dated 6/18/25 revealed no documentation of orders for an indwelling catheter. A phone interview with Licensed Practical Nurse (LPN) #2 on 6/24/25 at 9:15 AM confirmed she admitted Resident #105 on 6/19/25 and stated that the resident was admitted from the hospital with the catheter. She confirmed she did not notify the provider or the nurse practitioner to obtain any orders related to the need to keep the catheter. She stated that it was not their practice, and stated they just put the facility orders in for	M 655	facility with a foley catheter present has the ability to be affected by the deficient practice. 3. On 6/24/2025, Licensed Practical Nurse (LPN) # two (2) was in-serviced by the facility Staff Development Coordinator (SDC) on communicating with the Medical Director or Nurse Practitioner if a resident is admitted to the facility with a foley catheter present but no orders from referring hospital. The facility SDC also in-serviced all LPN's and RN's regarding communicating with the Medical Director or Nurse Practitioner if a resident admitted with a foley catheter present but no orders from referring hospital on 6/24/2025. 4. Beginning 6/30/2025, facility Medical Records Nurse or Director of Nursing (DON) will audit any admissions to determine if resident had foley catheter present on admission, if hospital discharge orders included foley catheter and if not was the facility Medical Director or Nurse Practitioner notified five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for three (3) months. Medical Records Nurse or DON will bring results of the audit to monthly Quality Assurance meeting for review and discussion beginning 7/21/2025. The Quality Assurance meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial Quality Assurance meeting was held on 6/27/2025 to discuss and implement the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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) COMPLETE DATE
M 655	Continued From page 12 the catheter, and the nurse practitioner would make that decision when she sees the resident if the catheter is needed or not. Record review of the "Order Summary Report" of active orders for Resident #105 revealed no order for the justification of the need for the indwelling catheter. In a follow-up interview with RN #1 on 6/24/25 at 9:25 AM, she confirmed that Resident #105 had not yet been seen by the provider or the nurse practitioner. During an interview with the Director of Nursing (DON) on 6/24/25 at 9:34 AM, she confirmed that if a resident admits from the hospital with a catheter, the admitting nurse should notify the provider for orders to either leave the catheter in or discontinue it, and confirmed the nurse should not put in the batched facility standing catheter orders without the provider's approval for the need of the catheter. She stated concerns about leaving a catheter in without a proper reason is the increased risk of infection. Record review of the "Admission Record" revealed Resident #105 was admitted by the facility on 6/19/25 with a diagnosis of benign prostatic hyperplasia without lower urinary tract symptoms. Record review of Resident #105's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact.	M 655		