Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE CENTER	**111 CHASE STREET , BYHALIA, Mississippi, 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) COMPLETION DATE
M0000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI #2638002) at the facility from 11/05/25 through 11/06/25. During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA identified noncompliance and cited M735 related to Medical Records Management. The census at the time of the survey was 47 residents, with a bed capacity of 60 beds.	M0000		
M0735 SS = D	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary,	M0735		

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

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M0735 SS = D	Continued from page 1 including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	M0735		

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M0735 SS = D	Continued from page 2 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.	M0735		