STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #2704344) at the facility from 03/09/26 through 03/12/26. CI MS #2704344 was investigated for confidentiality and privacy; there were no citations related to this complaint. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F558, F565, F602, F628, F641, F656, F658, F693, F698, F757, and F761. The facility had a census of 105 and was licensed for 120 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0550 SS = D	Continued from page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review, and staff interviews, the facility failed to ensure staff treated residents with dignity and respect for two (2) of 24 residents reviewed for dignity (Resident #44 and Resident #84). Findings include: Review of the facility policy titled “Resident Rights and Responsibilities" with a revision date of 10/10/2022, revealed, "The resident has a right to be treated with respect and dignity..." Resident #44 During a resident interview conducted on 3/09/2026 at approximately 2:34 PM, Resident #44 stated that Certified Nursing Assistant (CNA) #2 had been rude to her. The resident stated that her son had washed her laundry and brought it back to the facility and when she asked the CNA to help her put her clothes away, the CNA stated, “I’m not laundry.” During an interview conducted with the Unit Manager Registered Nurse (RN) #1 on 3/10/2026 at approximately 2:05 PM, the Unit Manager stated the resident had previously complained that a CNA had been rude to her. The Unit Manager stated the CNA reportedly told the resident that her son should have folded her clothes. The Unit Manager stated the comment made the resident feel bad because she is close to her son. The Unit Manager stated she had a meeting with CNA #2 and spoke with her about how she speaks to residents. During an interview conducted with the Administrator and Assistant Director of Nursing (ADON) on 3/10/2026 at approximately 2:25 PM, the Administrator and ADON stated they were unaware the resident had reported the aide being rude to her and stated they were unaware of any education or in-service provided to the CNA regarding the concern. They stated, “We expect our staff to treat residents with dignity and respect.” During an interview conducted	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0550 SS = D	Continued from page 2 with CNA #2 on 3/12/2026 at approximately 10:05 AM, the CNA confirmed the resident had asked for help putting her clothes away. CNA #2 stated she told the resident, “I’m not laundry,” and acknowledged the statement could have been perceived as rude. CNA #2 confirmed that she should have just helped the resident with her needs. Record review of the Admission Record revealed the facility admitted Resident #44 on 11/27/2020 with diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/2025 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #44 was cognitively intact. Resident #84 On 3/11/2026 at approximately 12:53 PM, an observation was conducted of Licensed Practical Nurse (LPN) #6 providing Percutaneous Endoscopic Gastrostomy tube (PEG) site care to Resident #84. During the observation, the LPN closed the privacy curtain between residents but left the door open while providing care. Resident #84 was sitting close to the door during the care, and another resident was wheeled by in a wheelchair and waved at Resident #84 during the care.When asked about privacy and dignity during the observation, LPN #6 stated she forgot to close the door, and residents should be treated with dignity and have privacy during care. During an interview with the Director of Nursing (DON) on 3/11/26 at 2:30 PM, the DON stated the door should have been closed and residents should have privacy and be treated with dignity and respect. Record review of the Admission Record revealed the facility admitted Resident #84 on 10/20/2022 with diagnoses that included Malignant Neoplasm of Larynx. Record review of the MDS with an ARD of 12/07/2025 revealed under Section C, a BIMS score of 10, indicating moderate cognitive impairment.	F0550		
F0558 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 observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure residents’ call lights were placed within reach for two (2) of 24 sampled residents. (Resident #11 and #104)	F0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0558 SS = D	Continued from page 3 Findings Include: Review of the facility policy titled, “Call Lights: Accessibility and Timely Response,” with an effective date of 10/10/2022 revealed “Staff will ensure the call light is within reach of the resident and secured, as needed.” Resident #11 An observation on 3/09/2026 at 11:15 AM revealed Resident #11 asleep and seated in a reclined position in her recliner without access to a call light. Two (2) call lights were observed wrapped around the bed rail and were not within reach of the resident. On 3/09/2026 at 12:25 PM, a subsequent observation revealed the resident remained asleep in the same reclined position in the recliner, and the call lights remained wrapped around the bed rail and inaccessible to the resident. During an observation and interview on 03/09/2026 at 2:55 PM, Resident #11 remained seated in a reclined position in the recliner with no call light accessible. Resident #11 revealed she had experienced falls in the past and stated that was the reason both call lights were wrapped around the positioning bar on her bed. The resident confirmed she was unable to reach a call light or notify staff if assistance was needed while sitting in the recliner and further stated, “I guess I should have one of those call lights over at my recliner.” During an interview and observation on 3/10/2026 at 11:00 AM, Certified Nurse Aide (CNA) #1 revealed that Resident #11 is at risk for falls and confirmed both call lights had been wrapped around the bed rails. CNA #1 further confirmed there was no call light positioned next to the resident when she was sitting in the recliner. CNA #1 stated, “Staff is expected to make more frequent rounds on the resident and acknowledged this should have been noticed.” Record review of the Admission Record revealed the facility admitted Resident #11 on 11/01/2024 with medical diagnoses that include Parkinson’s Disease, Muscle weakness, and Difficulty in walking. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 2/21/26 revealed a Brief Interview of Mental Status (BIMS) score of 12, which indicated Resident #11 has moderate	F0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0558 SS = D	Continued from page 4 cognitive impairment. Resident #104 During an observation and interview on 3/9/26 at 10:20 AM, Resident #104 was observed sitting in a recliner approximately ten (10) feet away from his bed. The residents call light was observed lying on top of the overbed light fixture and was not accessible to the resident. Resident #104 stated, “I’m not sure how long that has been lying up there. I guess they put it up there when they buffed my floors.” Resident #104 further stated, “I can’t reach it anyway, especially when I’m in my recliner.” During an interview on 3/10/26 at 11:10 AM, Licensed Practical Nurse (LPN) #1 revealed the resident is impulsive and noncompliant; however, she confirmed the resident’s call light should always be accessible to him. During an observation and interview on 3/10/26 at 11:15 AM, Resident #104 was observed sitting in his recliner with the call light wrapped around the base of the overbed table and not within reach of the resident. CNA #1 confirmed the call light was inaccessible to the resident and repositioned the overbed table next to the resident so he could reach it. Resident #104 stated to CNA #1, “Yesterday, it was up on top of the overbed light when she came in. They must have put it up there when they buffed the floors. During an interview on 3/10/26 at 11:35 AM, the Assistant Director of Nursing (ADON) confirmed that it is the facility’s expectation that call lights remain within residents' reach so they can notify staff when assistance is needed. During an interview on 3/10/26 at 3:50 PM, the Administrator confirmed that call lights should always be within reach of residents and acknowledged that call lights not being accessible could delay care needed by the resident. Record review of the Admission Record revealed the facility admitted Resident #104 on 2/18/22 with medical diagnoses that include Osteoarthritis, Muscle weakness, and unsteadiness on feet. Record review of the MDS Section C with an ARD of 12/22/25 revealed a BIMS score of 08, which indicated	F0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0558 SS = D	Continued from page 5 Resident #104 has moderate cognitive impairment.	F0558		
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on Resident Council interviews, staff interviews, record review and facility policy review, the facility failed to implement an effective grievance process to ensure resident concerns were received, tracked, investigated, and resolved for three (3) of six (6)	F0565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0565 SS = D	Continued from page 6 months of Resident Council meeting minutes reviewed. Findings include: Review of facility policy titled "Grievance Policy" with revised date 10/6/2025, revealed, "...The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility...issuing written grievance decisions to the resident...3. A resident...may voice grievances with respect to care and treatment that has been furnished...the behavior of staff...and other concerns regarding their LTC (long term care) facility stay...7. Grievances may be voiced in the following forums...d. Verbal complaint during resident or family council meetings...9. d. The Grievance Official will take steps to resolve the grievance, record information about the grievance, and those actions on the grievance form...e. The Grievance Official...will keep the resident appropriately apprised of progress towards resolution of the grievances...10. Evidence demonstrating the results of all grievances will be maintained for a period of no less than three (3) years from the issuance of the grievance decision...11. The facility will make prompt efforts to resolve grievances." On 03/10/26 at 2:00PM the State Agency (SA) held a Resident Council meeting with Resident #12, Resident #21, Resident #22, Resident #25, Resident #35, Resident #39, Resident #43, Resident #46, Resident #52, Resident #65, Resident #67, Resident #96, Resident #104 and Resident #110 in attendance. When residents were asked if they had grievances that had not been addressed by the facility, 14 of the 16 residents' present reported they had voiced grievances to facility staff that had not been resolved and that it was in the meeting minutes. The residents stated that facility staff generally treated them well; however, they expressed multiple concerns regarding agency staff. Residents reported they were tired of having agency staff and stated that agency staff did not provide continuity of care because they did not know the residents or the facility routines. They stated that agency staff were frequently on their phones, they were rude and appeared uninterested in providing care. Residents also complained that agency nurses took excessive time to pass evening medications. Several residents stated that medications scheduled for 7:00–8:00 PM were sometimes not administered until 10:00–11:00 PM when agency nurses were working. Residents reported that these concerns had been ongoing for several months and stated the issues had been discussed repeatedly during	F0565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0565 SS = D	Continued from page 7 Resident Council meetings. Residents indicated that the Licensed Social Worker (LSW) was aware of these concerns; however, they reported they had not received follow-up regarding their complaints and were unaware of any grievance investigation or outcomes. Record review of Resident Council meeting minutes dated 10/14/25, revealed, "...Old Business...Medications (not getting medications on time (mainly "agency staff" nurses) having to wait until after 10/11 to get 8:00 meds-Only with agency..." Record review of Resident Council meeting minutes dated 11/13/25, revealed, "...New Business...Bad attitudes from Agency staff..." Record review of Resident Council meeting minutes dated 12/9/25, revealed, "...Old Business...Bad attitudes from Agency staff-no change..." During an interview conducted on 3/10/26 at 3:25 PM with the Administrator and the Assistant Director of Nursing (ADON), they confirmed the facility had experienced problems with agency staff in the past, but stated each situation was addressed individually when complaints were reported. The Administrator and Assistant Director of Nursing (ADON) both confirmed that they didn't consider this issue a grievance and the things they considered to be grievances would be something such as missing items or missing clothing. When they were asked to describe the facility's grievance process, neither the Administrator nor the ADON were able to clearly describe the process. Both stated that the LSW handled grievances but did not provide additional information regarding how grievances were received, investigated, tracked, or how outcomes were communicated to residents. The Administrator and ADON did not indicate that grievances raised during Resident Council meetings regarding agency staff behavior and delayed medication administration would be considered grievances requiring investigation and follow-up. On 03/11/2026 at 8:24 AM, an interview was conducted with the Licensed Social Worker (LSW), she stated she was responsible for handling grievances and confirmed that she attended the resident council meetings each month. When asked about residents' grievances regarding how they were treated by agency staff, the LSW stated, "It's written in every Resident Council meeting," and confirmed that the issue had not been resolved. Record review of the "Admission Record" indicated that the facility admitted Resident #12 on 9/4/2024 with a	F0565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0565 SS = D	Continued from page 8 medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13 which indicated Resident #12 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #21 on 4/12/2022 with a medical diagnosis that included Cerebral Infarction, Unspecified. A record review of the MDS with an ARD of 3/4/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #21 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #22 on 2/14/2025 with a medical diagnosis that included Other Schizophrenia. A record review of the MDS with an ARD of 2/14/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #22 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #25 on 1/8/2019 with a medical diagnosis that included Cerebral Infarction, Unspecified. A record review of the MDS with an ARD of 12/14/25 revealed under section C, a BIMS summary score of 13 which indicated Resident #25 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #35 on 5/23/2024 with a medical diagnosis that included Other Cerebrovascular Disease. A record review of the MDS with an ARD of 2/10/26 revealed under section C, a BIMS summary score of 14 which indicated Resident #35 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #39 on 12/3/2025 with a medical diagnosis that included Type 2 Diabetes Mellitus without complications. A record review of the MDS with an ARD of 2/5/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #35 was cognitively intact.	F0565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0565 SS = D	Continued from page 9 Record review of the "Admission Record" indicated that the facility admitted Resident #43 on 11/14/2025 with a medical diagnosis that included Chronic Kidney Disease, Stage 4. A record review of the MDS with an ARD of 2/17/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #43 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #46 on 11/16/2022 with a medical diagnosis that included Acute Upper Respiratory Infection. A record review of the MDS with an ARD of 1/29/26 revealed under section C, a BIMS summary score of 14 which indicated Resident #46 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #52 on 2/6/2026 with a medical diagnosis that included Epilepsy, Unspecified, Not Intractable, with Status Epilepticus. A record review of the MDS with an ARD of 1/19/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #52 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #65 on 8/22/2025 with a medical diagnosis that included Hypothyroidism. A record review of the MDS with an ARD of 2/23/26 revealed under section C, a BIMS summary score of 12 which indicated Resident #65 had moderate cognitive impairment. Record review of the "Admission Record" indicated that the facility admitted Resident #67 on 8/11/2025 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. A record review of the MDS with an ARD of 12/24/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #67 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #96 on 11/3/2023 with a medical diagnosis that included Type 2 Diabetes Mellitus with hyperglycemia. A record review of the MDS with an ARD of 1/27/26 revealed under section C, a BIMS summary score of 13 which indicated Resident #96 was cognitively intact.	F0565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0565 SS = D	Continued from page 10 Record review of the "Admission Record" indicated that the facility admitted Resident #104 on 2/18/2022 with a medical diagnosis that included Moderate Protein-Calorie Malnutrition. A record review of the MDS with an ARD of 12/22/25 revealed under section C, a BIMS summary score of 8 which indicated Resident #104 had moderate cognitive impairment. Record review of the "Admission Record" indicated that the facility admitted Resident #110 on 7/17/2013 with a medical diagnosis that included Multiple Sclerosis. A record review of the MDS with an ARD of 12/4/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #110 was cognitively intact.	F0565		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents were free from misappropriation of resident property when a nurse removed medication dispensed for one resident and administered it to another resident for one (1) of twenty five (25) medication administration opportunities reviewed (Resident #67). Findings Include: Review of the facility policy titled “Abuse, Neglect, and Exploitation” revised 10/22 revealed under, “Policy: This facility’s policy is to protect each resident’s health, welfare, and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.”	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0602 SS = D	Continued from page 11 Record review of Resident #46's March 2026 Medication Administration Record (MAR) revealed an order dated 1/1/26, "Seroquel oral tablet 200 MG (milligrams) give 1 (one) tablet by mouth one time a day" due at 0800 (8 AM). On 3/11/26 at 7:30 AM, an observation of a medication pass with Licensed Practical Nurse (LPN) #5 revealed the LPN did not have Resident #46's ordered Seroquel 200 milligram tablet and stated Resident #46 was out of the medication. LPN #5 then removed two (2) 100 milligram tablets from Resident #67's Seroquel medication card and administered the medication to Resident #46. Record review of Resident #67's March 2026 MAR revealed an order dated 8/11/25, "Seroquel oral tablet 100 MG (milligrams) give one (1) tablet by mouth at bedtime." An interview with LPN #5 on 3/11/26 at 8:46 AM confirmed he borrowed Resident #67's Seroquel to administer to Resident #46. He explained that he was not aware that he was not supposed to borrow medications and acknowledged Resident #67 lost two (2) doses of his medication which could create a medication shortage for him. LPN #5 further acknowledged medications belong to the resident for whom they were dispensed. An interview with the Director of Nursing (DON) on 3/11/26 at 1:39 PM confirmed medications should not be borrowed and stated the facility had a backup pharmacy available when medications were out of stock. She acknowledged medications dispensed by the pharmacy were considered the property of the resident for whom they were prescribed. Record review of the "Admission Record" revealed the facility admitted Resident #67 on 8/11/25 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Left Non Dominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/24/25 revealed under section C, a Brief Interview for Mental Status	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0602 SS = D	Continued from page 12 (BIMS) summary score of 15, indicating Resident #67 was cognitively intact.	F0602		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0628 SS = D	Continued from page 13 in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0628 SS = D	Continued from page 14 form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0628 SS = D	Continued from page 15 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure written notification of a resident's hospital transfer was provided to the residents Resident Representative (RR) in accordance with transfer and discharge requirements for one (1) of two (2) residents reviewed for	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0628 SS = D	Continued from page 16 hospitalization. Resident #8 Findings Include: Review of the facility policy titled “Transfer and Discharge,” revised 2/10/25, revealed, “4. The facility’s transfer/discharge notice will be provided to the resident and the resident’s representative in a language and manner in which they can understand.” An interview with Resident #8 on 3/9/26 at 10:28 AM revealed she transferred from the facility to the hospital in January for a bowel perforation that required surgical repair. Record review of Resident #8’s “Progress Notes,” dated 1/1/26, revealed the resident was transferred to the emergency room for severe abdominal pain. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/1/26 revealed an Admission 5-Day combined with a discharge return anticipated MDS was completed. An interview with Social Services on 3/11/26 at 11:35 AM confirmed she did not mail a written notice of hospital transfer to Resident #8’s representative because the resident had been in the facility less than 24 hours when she was transferred out. Record review of the “Admission Record” revealed the facility re-admitted Resident #8 on 2/4/26 with medical diagnoses that included Unspecified Open Wound of Abdominal Wall. Record review of the MDS with an ARD of 2/11/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 7, indicating Resident #8 was moderately cognitively impaired.	F0628		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0641 SS = D	Continued from page 17 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review the facility failed to accurately complete "Section N" of the Minimum Data Set (MDS) assessment during the 7-day observation look-back period for two (2) of five (5) residents reviewed for unnecessary medication usage. Resident #11 and Resident #28. Findings Include: Review of facility policy titled "MDS Assessments" with revision date 3/11/2026, revealed, "Policy: The purpose of this policy is to ensure that all residents receive an accurate assessment, reflective of the residents' status at the time of the assessment, by staff qualified to assess relevant care areas..." Resident #11 A record review of the “Order Summary Report” revealed that Resident #11 has an order for Clonazepam oral	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0641 SS = D	Continued from page 18 tablet 0.5 milligram (mg.) Give 1 tablet by mouth every 12 hours related to anxiety disorder, with a start date of 1/6/26. Record review of Resident #11's Quarterly MDS with an Assessment Reference Date (ARD) of 2/3/26, revealed under section N, that Resident #11 did not receive seven (7) days of anti-anxiety medication for the observation look back period of 1/28/26 through 2/3/26. Record review of the Electronic Medication Administration Record (eMAR) for the MDS 7-day observation look-back period for antianxiety medication revealed Resident #11 received an anxiety medication between 1/28/26 and 2/3/26. An interview with the MDS Coordinator on 3/11/26 at 11:35 AM confirmed that Resident #11 was not coded on the 7-day look-back period for receiving an antianxiety medication. She confirmed the resident takes Clonazepam for her anxiety, and it should have been coded on her Quarterly MDS assessment. Record review of the Admission Record revealed the facility admitted Resident #11 on 11/01/2024 with medical diagnoses that include Generalized Anxiety Disorder. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 2/21/26 revealed a Brief Interview of Mental Status (BIMS) score of 12, which indicated Resident #11 has moderate cognitive impairment. Resident #28 Record review of Resident #28's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/31/2025, revealed section N300 and N350 were coded incorrectly related to Resident #28 receiving insulin injections during the review lookback period. Record review of Resident #28's Medication Administration Record (MAR) for December 2025 revealed Resident #28 was not administered insulin at all during the month of December 2025. On 03/11/2026 at 2:42 PM, an interview was conducted	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0641 SS = D	Continued from page 19 with Minimum Data Set (MDS) Coordinator, and she confirmed that the Quarterly MDS assessment with an ARD of 12/31/2025 was coded incorrectly. The MDS Coordinator reviewed the December MAR and verified that Resident #28 did not receive insulin injections during the month of December 2025. The MDS Coordinator stated that the assessment had been completed by a Licensed Practical Nurse (LPN) and acknowledged that she was responsible for reviewing the assessment prior to signing and submitting it. The MDS Coordinator acknowledged that she did not always fully review assessments completed by other nursing staff prior to signing and submitting them, despite confirming that her signature verified the accuracy of the information contained in the assessment. The MDS Coordinator confirmed that by signing the assessment she was verifying that the information contained in the assessment was accurate. She further stated that inaccurate coding of the MDS assessment has the potential to affect the accuracy of resident assessment data used for care planning, quality measures, and facility reimbursement. During an interview conducted on 03/11/2026 at 2:46 PM with the Director of Nursing (DON), she stated that her expectation is for MDS assessments to be completed timely and accurately. Record review of the "Admission Record" indicated that the facility admitted Resident #28 on 1/28/2008 with a medical diagnosis that included Type two (2) diabetes mellitus with diabetic polyneuropathy. A record review of the MDS with an ARD of 12/31/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #28 was cognitively intact.	F0641		
F0656 SS = G	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 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0656 SS = G	Continued from page 20 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, record review, resident and staff interviews, the facility failed to develop and implement comprehensive, person-centered care plans for three (3) of twenty-four (24) residents reviewed (Residents #5, #17, and #84). Specifically, the facility failed to develop care plan interventions addressing a physician-ordered fluid restriction for a resident receiving hemodialysis, failed to ensure the safe implementation of care plan interventions for a resident receiving Percutaneous Endoscopic Gastrostomy (PEG) tube feedings, and failed to develop and implement a care plan addressing a resident’s repeated refusal of physician-ordered weights. These failures	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0656 SS = G	Continued from page 21 resulted in Resident #5 exceeding the ordered fluid restriction and experiencing fluid volume overload requiring hospitalization and placed Residents #17 and #84 at risk for unsafe administration of tube feedings, inaccurate monitoring of intake, and lack of staff guidance for managing ongoing refusals of ordered care. Findings include: Review of the facility policy titled “Comprehensive Plan of Care,” revised 02/17/2025, revealed, "It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident... that includes measurable objectives and timeframes to meet the resident’s medical, nursing, and psychosocial needs and all services identified in the resident’s comprehensive assessment..." Resident #5 On 3/09/2026 at 3:12 PM, during an interview conducted with Resident #5 the resident communicated by writing on a white board that she had recently been hospitalized. Record review revealed Resident #5 received hemodialysis on Monday, Wednesday, and Friday and had a physician order for a 1000 milliliter (ml) fluid restriction per day. Physician diet orders revealed the resident was ordered a renal diet with a 1000 milliliter fluid restriction, allowing 240 ml with each meal and 70 cubic centimeters (cc) with each medication pass. Record review of Nurses Notes dated 01/02/26 at 10:44 AM stated, "Resident found to be in respiratory distress, oxygen (O2) 76%, on 3L (liters), Respiratory 30, Manual Blood pressure 150/68. O2 increased to 86% on 5L. Resident appearing weak and unable to ambulate safely independently, NP (Nurse Practitioner) at bedside with orders to send resident to ER (Emergency Room) for respiratory distress." Record review of hospital records revealed the resident was hospitalized on 01/02/26 for volume overload and discharged on 1/03/2026. The hospital assessment noted the resident “presented with volume overload symptoms related to getting too much fluid at the nursing home.” Record review of the resident’s care plan revealed interventions addressing hemodialysis; however, the care plan did not include interventions to monitor or maintain the physician-ordered fluid restriction or to	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0656 SS = G	Continued from page 22 notify the physician when fluid restriction was exceeded. An interview conducted with the Assistant Director of Nursing (ADON), Director of Nursing (DON), and Administrator on 3/11/2026 at approximately 2:05 PM revealed residents with fluid restrictions should have monitoring in place to ensure ordered fluid limits are not exceeded and the physician should be notified if restrictions are exceeded. Record review of the Admission Record revealed the facility admitted Resident #5 on 8/27/2025 with diagnoses including End Stage Renal Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Section O of the MDS revealed the resident received dialysis services while residing in the facility. Resident #84 On 3/09/2026 at 11:00 AM, Resident #84 was observed in his room administering a brown liquid through his PEG tube using a syringe. Record review revealed there were no physician orders indicating the resident was permitted to independently administer tube feeding or supplements through the PEG tube. Review of the care plan interventions did not address the resident independently administering tube feeding or supplements. Record review also revealed no documentation indicating the resident had been assessed for the ability to safely self-administer tube feeding or supplements. An interview conducted with the MDS Coordinator on 3/12/2026 at approximately 9:00 AM revealed the comprehensive care plan should include interventions addressing physician orders and resident needs identified in the resident's comprehensive assessment. The MDS Coordinator stated care plans should include interventions for monitoring physician-ordered fluid restrictions for Resident # 5 and for Resident # 84 who receives dialysis and interventions to ensure tube feedings are administered safely according to physician orders. Record review of the Admission Record revealed the facility admitted Resident #84 on 10/20/2022 with	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0656 SS = G	Continued from page 23 diagnoses including Malignant Neoplasm of the Larynx. Record review of the MDS with an ARD of 12/07/2025 revealed under Section C, a BIMS score of 10, indicating moderate cognitive impairment. Resident #17 Record review of Resident #17's care plan with Licensed Practical Nurse (LPN) #3 revealed the resident's ongoing refusal of weights had not been addressed in the care plan. LPN #3 stated, "She has refused to be weighed since she was admitted." Record review of Resident #17's Order Summary dated 3/10/26 revealed a physician order for monthly weights dated 8/6/2024. Record review of Resident #17's weight record revealed the resident had not been weighed since the initial admission weights. During an interview on 3/10/2026 at 11:32 AM, the Assistant Director of Nursing (ADON) confirmed a care plan addressing the resident's refusal of weights had not been developed. The ADON stated Resident #17 had consistently refused to be weighed and that the physician and the resident's family were aware of the resident's refusals. Record review of care plan revealed no care plan had been developed to address the resident's refusal of monthly weights as ordered by the physician. During an interview on 3/11/2026 at 12:15 PM, the MDS Nurse stated that a care plan should have been developed once the resident demonstrated an ongoing pattern of refusing physician-ordered services. She further stated that the purpose of the care plan is to guide staff in providing appropriate care for the resident. Record review of the "Admission Record" indicated that the facility admitted Resident #17 on 5/3/2024 with a medical diagnosis that included Secondary Hypertension. A record review of the Minimum Data Set (MDS) with an ARD of 1/14/26 revealed under section C, a BIMS summary score of 13 which indicated Resident #17 was cognitively intact.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0658 SS = D	Continued from page 24 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure medications were prepared and administered by the same nurse in accordance with accepted nursing standards of practice for one (1) of six (6) residents observed during medication pass (Resident #98). Findings Include: Review of the facility policy titled “Medication Administration,” revised 6/8/23, revealed under, “Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.” An observation on B-Hall on 3/11/26 at 7:58 AM revealed Licensed Practical Nurse (LPN) #4 removed a medicine cup containing prepared medications from the top of the medication cart and handed them to Registered Nurse (RN) #2, requesting that she administer the medications to Resident #98. RN #2 accepted the cup of medication and proceeded to Resident #98’s room to administer them. An interview on 3/11/26 at 8:06 AM with LPN #4 and RN #2 confirmed LPN #4 prepared Resident #98’s medications and handed them to RN #2 to administer. RN #2 acknowledged this was not a safe medication administration practice and stated the nurse who prepares the medication should be the one to administer it in order to reduce the risk of medication errors and maintain medication accountability. An interview with the Director of Nursing (DON) on 3/11/26 at 1:39 PM revealed only the nurse who prepares the medication should administer it and confirmed this was not an accepted nursing standard of practice.	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0658 SS = D	Continued from page 25 Record review of the “Admission Record” revealed the facility admitted Resident #98 on 5/28/25 with medical diagnoses that included Acute Respiratory Failure with Hypoxia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #98 was cognitively intact.	F0658		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interviews and facility policy review, the facility failed to ensure tube feeding or supplements administered through a Percutaneous Endoscopic Gastrostomy (PEG) tube were administered according to physician orders for one (1) of two (2) residents with a PEG tube (Resident #84). Findings include: Review of the facility policy titled “Enteral Nutrition,” revised 3/17/2023, revealed liquid	F0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0693 SS = D	Continued from page 26 nutritional supplements and substitutes will be given to the resident as ordered by the physician. On 3/09/2026 at 11:00 AM, Resident #84 was observed in his room administering a brown liquid through his PEG tube using a syringe. A record review conducted on 3/09/2026 revealed there were no physician orders indicating the resident was permitted to independently administer tube feeding or supplements through the PEG tube. Record review also revealed no documentation indicating the resident had been assessed for the ability to safely self-administer tube feeding or supplements. An interview conducted with Registered Nurse (RN) #1 on 3/10/2026 at 2:00 PM revealed the tube feeding formula or supplements must be administered by staff, and staff are responsible for monitoring the resident's intake. An interview conducted with the Administrator and Assistant Director of Nursing on 3/10/2026 at 2:20 PM revealed the resident should not have been independently administering liquids through his PEG tube. The Assistant Director of Nursing stated allowing the resident to administer liquids independently would prevent staff from accurately monitoring intake and output and ensuring the feeding was administered appropriately. Record review of the Admission Record revealed the facility admitted Resident #84 on 10/20/2022 with diagnoses that included Malignant Neoplasm of Larynx. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/2025 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.	F0693		
F0698 SS = G	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0698 SS = G	Continued from page 27 Based on resident interview, record review, and staff interviews, the facility failed to ensure fluid restrictions were implemented and monitored for one (1) of six (6) residents reviewed for dialysis services, resulting in fluid volume overload that required a hospitalization. (Resident #5). Findings include: The facility did not provide a policy related to monitoring or implementing fluid restrictions for residents. Review of a statement on facility letterhead dated 3/11/26 and signed by the Administrator revealed "(Proper Name of Facility) does not have a policy related to fluid restrictions or management of fluids. The staff follow physician orders." During an interview conducted with Resident #5 on 3/09/2026 at 3:12 PM, the resident communicated by writing on a white board and indicated she had recently been hospitalized. Record review revealed physician's order dated 08/28/25 for hemodialysis on Monday, Wednesday, and Friday and the resident had a physician order for a fluid restriction of 1000 milliliters (ml) per day. Record review of physician diet orders revealed Resident #5 was ordered a renal diet with a 1000 milliliter (ml) fluid restriction. The order indicated the resident may receive 240 ml with each meal and 70 cubic centimeters (cc) with each medication pass. Record review of Nurses Notes dated 01/02/26 at 10:44 AM stated, "Resident found to be in respiratory distress, oxygen (O2) 76%, on 3L (liters), Respiratory 30, Manual Blood pressure 150/68. O2 increased to 86% on 5L. Resident appearing weak and unable to ambulate safely independently, NP (Nurse Practitioner) at bedside with orders to send resident to ER (Emergency Room) for respiratory distress." Record review of hospital records revealed the resident was hospitalized on 01/02/26 for volume overload and discharged on 1/03/2026. The hospital assessment noted the resident "presented with volume overload symptoms related to getting too much fluid at the nursing home." Record review of the January 2026 Treatment Administration Record and Nurses Notes documentation revealed a lack of a continuous daily monitoring system to ensure the resident's fluid intake remained within the ordered restriction. Record review of "Assessment	F0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0698 SS = G	Continued from page 28 History," revealed a lack of intake and output (I&O) documentation in order to properly monitor I&O's for the following dates of 01/03/26 through 02/05/26. Record review of fluid intake documentation dated 2/26/2026, 02/27/26, 03/02/26, 03/03/26, 03/04/26, 03/06/26, 03/07/26 and 03/08/26 revealed the resident received 480 ml at three separate times for the 24-hour period totaling 1,440 ml, which exceeded the ordered 1000 ml fluid restriction. Record review further revealed the physician was not notified when the fluid restriction was exceeded on these dates. An interview conducted with a Certified Nursing Assistant (CNA) #3 on 3/11/2026 at 11:30 AM revealed CNA #3 stated that she used the drinking cups on the resident's meal tray to document the resident's intake. She demonstrated how for the daily meals the resident would have two (2) eight-ounce cups of juice and coffee for breakfast and 2 eight-ounce cups of liquid for the lunch and supper meals. CNA #3 confirmed that each eight-ounce cup is 240ml and it would total 480ml per meal for a total of 1,440ml per 24-hour period. CNA #3 confirmed that this would be over the daily fluid intake ordered by the physician. During an interview conducted with the Director of Nursing (DON) on 3/11/2026 at 11:45 AM, the DON stated that she was unaware that the resident was receiving over her total daily fluid amount and although staff were documenting fluid intake, they were not totaling the intake at the end of the shift and were not notifying the physician when the resident exceeded the ordered 1000 ml restriction. The DON confirmed that they needed to do a better job monitoring the fluid intake and that it was not always documented and tracked daily to prevent fluid volume overload. An interview conducted with the Administrator on 3/11/26 at 2:05 PM revealed residents with fluid restrictions should have monitoring in place to ensure ordered fluid limits are not exceeded and the physician should be notified if restrictions are exceeded and confirmed that this was not occurring for Resident #5. Interview on 03/11/26 at 3:00 PM with the dialysis nurse at the dialysis facility confirmed that Resident #5 had come to dialysis on 12/28/25, 12/30/25 and was scheduled to come for dialysis on 01/02/26 but had to be sent to the ER prior to her chair time due to fluid overload. Record review of the Admission Record revealed the facility admitted Resident #5 on 8/27/2025 with	F0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0698 SS = G	Continued from page 29 diagnoses that included End Stage Renal disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. MDS Section O revealed the resident received dialysis services while residing in the facility.	F0698		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure monitoring for adverse consequences of high-risk medications for one (1) of five (5) residents reviewed for medication regimen review. (Resident #4). Findings include: Review of the facility policy titled “High Risk	F0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0757 SS = D	Continued from page 30 Medications," effective 2/10/2025, revealed, "Policy: This facility recognizes that some medications are associated with a higher risk of adverse effects than others. These high-risk medications can include antidiabetics…The resident's plan of care shall alert staff to monitor for adverse consequences of any high-risk medications given…" Record review of Resident #4's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2026 revealed orders for "Insulin Glargine Solution 100 units/milliliter (U/ML), inject 98 units subcutaneously every 12 hours for diabetes mellitus (DM) related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION (E11.69)… Start Date 12/29/2025," and "Novolin R Injection Solution (Insulin Regular (Human)), inject 77 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION (E11.69)…Start Date 12/04/2023." Review of the MAR and TAR lacked evidence of daily monitoring for signs and symptoms of hypoglycemia or hyperglycemia. During an interview on 03/11/2026 at 12:24 PM, the Director of Nursing (DON) confirmed monitoring for signs and symptoms of hypoglycemia and hyperglycemia had not been implemented for Resident #4. The DON stated the facility maintains standing orders requiring monitoring for diabetic residents and stated that physician orders are reviewed monthly by administrative nursing staff, and this issue should have been identified during that review process. The DON explained that monitoring for hypoglycemia and hyperglycemia is necessary to help prevent an episode from progressing into a medical emergency that could require hospitalization or result in serious harm. Record review of the "Admission Record" indicated that the facility admitted Resident #4 on 4/23/2019 with medical diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated Resident #4 was cognitively intact.	F0757		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0761 SS = D	Continued from page 31 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, and medication competency checklist review, the facility failed to ensure that insulin was properly labeled and stored in accordance with professional standards and manufacture's instruction for use after opening for one (1) of two (2) medication carts reviewed. C hall medication cart Findings Include: Review of the "Medication Administration Competency Checklist" revealed under, "23. Insulin dated when open." Also revealed under, "24. Insulin discarded after 28 days per manufacturer's instructions." An observation of the medication cart on C hall with Licensed Practical Nurse (LPN) #5 on 3/11/26 at 12:32 PM revealed the following insulins were in use and exceeded the manufacturer's 28-day room temperature storage limit or were not dated when opened: Resident #1 – Open vial of Insulin Lispro without an	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD , OXFORD, Mississippi, 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
F0761 SS = D	Continued from page 32 open date Resident #13 – Insulin Lispro vial with an open date of 1/2/26 Resident #13 – Insulin Glargine insulin pen without an open date Resident #44 – Insulin Aspart with an open date of 1/17/26 Resident #46 – Insulin Aspart with an open date of 1/30/26 Resident #46 – Fiasp Insulin with an open date of 1/25/26 Resident #67 – Insulin Lispro vial with an open date of 1/30/26 Record review of the manufacturer's storage instructions for Fiasp insulin, Insulin Lispro, Insulin Aspart, and Insulin Glargine revealed that once opened these insulins may be stored at room temperature for up to 28 days, after which the product should be discarded. An interview with LPN #5 on 3/11/26 at 12:48 PM confirmed the insulins were in use and were expired past the 28 days that insulin may be stored at room temperature. He revealed that once insulin was expired it lost its potency and may not be as effective at controlling residents' blood sugars. He confirmed Resident #1 and Resident #13 had insulin in use that was not labeled with an open date, revealing staff could not determine if they were administering expired insulin. An interview with the Director of Nursing (DON) on 3/11/26 at 1:39 PM revealed the insulin should be removed from the medication carts after 28 days from the open date. She stated the nurses were responsible for checking the insulins and ensuring they were not expired. The DON acknowledged that lack of dating the insulin when opening and the use of out-of-date insulin could cause the insulin to not be as effective.	F0761		