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 **05/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS REHABILITATION AND HEALTHCARE CENTER	**3716 HIGHWAY 39 NORTH , MERIDIAN, Mississippi, 39301**

(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), MS #2967639, at the facility from 5/6/26 through 5/7/26. CI MS #2967639 was investigated for accidents and nursing services. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and M640 was cited.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the environment remained as free of accident hazards as possible as evidenced by failure to investigate an initial fall, implement interventions to prevent recurrence, and ensure the resident's bed was maintained in a low position for one (1) of four (4) residents reviewed for accidents. Resident #1 Findings include: A review of the facility's policy, "Fall Prevention Program," dated 11/7/25, revealed "…Each resident will…receive care services in accordance with their individual level of risk to minimize the likelihood of falls…Policy Explanation and Compliance Guidelines…9. When any resident experiences a fall, the facility will…d. Complete an incident report…" A record review of the "Nursing Progress Note," dated 3/27/26 at 7:22 AM, for Resident #1 revealed, "….Nurse called to room at 0710 (7:10 AM). Found resident on floor…Called (proper name of ambulance service)…Will notify AM (morning) nurse…" A record review of the "ED (Emergency Department)" information for Resident #1 from a local acute care	M0640		

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

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M0640	Continued from page 1 hospital, dated 3/27/26 at 8:06 AM, revealed, "…Chief Complaint Patient presents with Fall…NH (Nursing Home) staff reports that she was found on the floor this morning…" A review of the clinical record for Resident #1 revealed there was no facility fall investigation completed for the fall that occurred on 3/27/26 at 7:10 AM. A record review of the "Nursing Progress Note," dated 3/27/26 at 2:59 PM, for Resident #1 revealed, "…Called to resident's room. Resident was noted lying on floor on right side…Resident remained on floor until (Proper Name of Ambulance Service) arrived…RP (Responsible Party) called and made aware. Requested to send to (Proper Name of Another Local Acute Care Hospital)…" A record review of the "Emergency Department" information for Resident #1 from another local acute care hospital, revealed, "…arrival 3/27/26 14:36 (2:36 PM)…Chief complaint Fall…EMS (emergency medical services) reports that patient was picked up from (first local acute care hospital ED) and taken back to nursing home. EMS reports shortly after, nursing home called with a reports that patient was found on the floor…" A record review of the facility's "Fall" investigation for Resident #1, dated 3/27/26 at 1:45 PM, revealed "…Incident Description…Nursing Description: Resident noted on the floor face down, in between bed and end table…" The report was prepared by Registered Nurse (RN) #1. On 5/6/26 at 9:45 AM, during an interview with Emergency Medical Technician (EMT) Student #1, he stated he and the EMT transported Resident #1on 3/27/26 after a fall at the facility. He reported the resident had also been transported to a hospital earlier the same day and was returned to the facility. He reported Emergency Medical Services (EMS) had left the facility and were called back within minutes due to Resident #1 having another fall. He stated he did not believe the resident could have flipped over the bedrails. He reported Resident #1 was placed in bed with the bedrails raised and the head of the bed elevated prior to EMS departure on 3/27/26. On 5/6/26 at 11:49 AM, during an observation of Resident #1, she was in her room, which was across from the nurses' station. Quarter length bedrails were present on the bed on each side and the bed was in the lowest position. Resident #1 was unable	M0640		

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M0640	Continued from page 2 to recall the fall event. On 5/6/26 at 12:23 PM, in an interview with Certified Nurse Aide (CNA) #2, she stated that when she had just arrived to work on the morning of 3/27/26 around 7:00 AM, Resident #1 was sent to the Emergency Room (ER). She stated when the resident returned from the hospital that afternoon, she had another fall within minutes. She stated the EMS personnel commonly leave resident beds elevated in a high position after returning residents to the facility. On 5/6/26 at 12:48 PM, during an interview with Registered Nurse (RN) #1, she explained Resident #1 had already been sent to the hospital for the first fall that occurred on 3/27/26 when she came on duty that morning. When Resident #1 returned to the facility by ambulance that afternoon, she entered the room with the EMT staff to assess the resident. She stated she left the room briefly to obtain vital sign equipment, and when she returned, Resident #1 was on the floor. She confirmed the bed was elevated. She stated Resident #1 had a raised area on her right forehead. RN #1 explained interventions put in place following the fall included keeping the bed in a low position and therapy services. She stated she did not complete a fall investigation report for the first fall for Resident #1 that occurred on 3/27/26 prior to her arrival to work. On 5/7/26 at 2:50 PM, in an interview with the Director of Nursing (DON), she stated the facility will implement a fall risk prevention program per facility policy and will implement fall interventions for the safety of the residents. A record review of the “Admission Record” for Resident #1 revealed the facility admitted Resident #1 on 3/8/25 and she had current diagnoses including of Metabolic Encephalopathy. A record review of the 5-Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated her cognition was severely impaired.	M0640		