STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	**310 EMERALD DRIVE , COLUMBUS, Mississippi, 39702**

(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 two (2) Complaint Investigations (CI MS# 2962385 and CI MS# 3005053) at the facility from 5/19/26 through 5/20/26. Although the facility was not cited directly related to the complaints, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and the facility was cited for deficient practices related to F 550 Resident Rights, F 578 Formulating Advanced Directives and F 761 Storage/Labeling. Census at the time of the survey was 87 with a bed capacity of 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

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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 record review, staff interview and facility policy review, the facility failed to ensure residents were treated with respect and dignity when a staff member spoke rudely and in a disrespectful manner to one (1) of three (3) residents reviewed. Resident #2 Findings included: Record review of the facility policy titled, “Resident Rights”, revealed “Standard, Employees shall treat all residents with kindness, respect and dignity...” Record review of “Grievance/Concern/Comment Report” dated 1/29/26, revealed that Resident #2’s family reported that Certified Nursing Assistant (CNA) #1 “talked down” to the resident and overheard CNA #1 state to the resident “I told you that I was coming back to change you!” An interview with the Social Services Director (SSD) on 5/20/26 at 8:35 AM, he stated he made a follow-up call to check on the resident after discharge and received report from the family that CNA #1 had “talked down” to the resident on the day of discharge. He stated he immediately reported the incident to the Director of Nursing (DON). An interview with the Administrator on 5/20/26 at 8:40 AM, she verified that the facility investigated the report and found that CNA #1 did not provide good customer service to Resident #2. The Administrator further verified that this meant that the CNA did not treat the resident with dignity and respect. She agreed that the resident should have been treated with dignity and respect.	F0550		

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F0550 SS = D	Continued from page 2 Record review of the “Admission Record” revealed the facility admitted Resident #2 on 10/10/25 with diagnosis that included Acute Respiratory Failure and discharged the resident home on 1/18/26.	F0550		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by:	F0578		

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F0578 SS = D	Continued from page 3 Based on staff interview, record review, and facility policy review the facility failed to ensure a resident was provided education and sufficient information regarding advance directives and the implications of assigning a Power of Attorney (POA) prior to obtaining the resident's agreement for one (1) of three (3) residents reviewed for advanced directives. Resident #1 Findings Included: Record review of the facility policy titled, "OBRA (Omnibus Budget Reconciliation Act) Resident Self-determination Checklist" revealed, "Policy…Every resident has the right to give informed consent before diagnosis or treatment. Advance Directives provide residents the ability to legally decide about their future medical treatment..." Record review of "Advance Health Care Directive," revealed the form was signed with Resident #1's name and notarized by the facility's Human Resources personnel on 2/19/26 making Resident #1's mother his health care agent. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 2/10/26 with diagnoses that included Aphasia follow Cerebral Infarction and Cognitive Communication Deficit. The "Admission Record" listed Resident #1's spouse as his Responsible Party (RP). An interview on 5/20/26 at 10:08 AM, with Human Resources (HR) verified that she was a Notary Public. She stated that on 2/19/26 she was called to the business office and introduced to Resident #1's mother. The mother asked her to come to the room and notarize paperwork. She explained that Resident #1's mother stated that they had an Advance Directive (AD) for Resident #1 that an alternative facility required in order to transfer him to that facility. HR stated that she asked Resident #1 if it was ok for his mother to sign his name and he indicated that it was. She stated that she verified the mother's identification and then notarized the paperwork. HR verified that she did not know who the Resident's RP was because she did not check his medical record to determine who was listed. She further stated that Resident #1 was not provided any explanation or education of the details of the "Advance Health Care Directive". She then added that the resident's ability to communicate "waxed and waned" throughout his stay indicating that the facility was unsure of his cognitive status. HR agreed that residents should receive education in order to make informed consent, she should have	F0578		

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F0578 SS = D	Continued from page 4 checked the chart to see who the RP was, and that she should not have notarized the “Advance Health Care Directive”. An interview with the Administrator on 5/20/26 at 12:46 PM she stated that facility staff are not to notarize any forms for residents and/or visitors and it was her expectation that HR would not have notarized the form. Record review of “Minimum Data Set” (MDS) Assessment with an Assessment Reference Date (ARD) of 2/17/26 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating that the resident was severely cognitively impaired.	F0578		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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 interview, and facility policy review the facility failed to ensure medications were stored in a safe and secure manner by leaving one (1) of eight (8) medication carts unlocked and unattended.	F0761		

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F0761 SS = D	Continued from page 5 Findings included: Record review of the facility policy, titled "Medication Storage" revealed "Policy Explanation and Compliance Guidelines, 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts…). An observation on 5/19/26 at 3:30 PM, revealed a medication cart located midway down the hall that was unlocked. Licensed Practical Nurse (LPN) #1 was noted to be down the hall away from the unlocked cart. An interview with LPN #1 on 5/19/26 at 3:36 PM, he verified that it was his medication cart and he did leave the cart unlocked. He agreed that he should have locked the cart before he walked away from it. He verified that leaving the cart unlocked and unattended could allow resident access to medications that could cause harm. An interview with the Administrator on 05/19/26 at 7:00 PM, she stated that it was her expectation that LPN #1 would have locked the cart before walking away.	F0761		