STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation CI MS #21115 at the facility from 5/9/23 through 5/12/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F580, F584, F637, F656, F660, F677, F689, F758, and F812. The SA found the facility to be in compliance related to CI MS #21115 and no deficiencies were cited. The census at the time of the survey was 108 and the facility was licensed for 120 beds.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		6/25/23

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

Electronically Signed | 05/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 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
F 660	Continued From page 1	F 660		

developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 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
F 660	Continued From page 2 data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to complete the discharge planning process for a resident that requested to transfer to another nursing facility for one (1) of four (4) residents reviewed. Resident #1 Findings include: Review of the facility policy titled, "TRANSFER AND DISCHARGE," revised 10/18/2022, revealed "c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility ... this orientation may be provided by various members of the interdisciplinary team ... e. The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge ... g. Supporting documentation shall include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or	F 660	• Resident #1 was discharged from the facility on 3/9/2023. • All residents who plan to discharge from the facility have the potential to be affected. • The licensed social worker has been in serviced by the company's social work consultant on proper discharge planning on 5/19/2023. • Quality Assurance nurse will audit 3 discharges a week for 4 consecutive weeks and then biweekly for 3 months to ensure proper discharge planning is done. Audits will begin 5/30/2023. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 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
F 660	Continued From page 3 resident representative." An interview on 5/11/23 at 9:30 AM, with Social Services revealed that Resident #1 had asked to be transferred to another nursing facility closer to his home in August 2022 but the Social Services department did not document it until March 7, 2023.. She confirmed she did not document her conversation with Resident #1 regarding his discharge planning request to go to another nursing facility closer to home. She stated she did not have a discharge care plan meeting, nor had she updated his discharge care plan regarding Resident #1's request to go to another nursing facility. She also confirmed that she had not developed a discharge plan with the interdisciplinary team to work on discharge to another nursing facility and had not documented that referrals were sent out to other nursing facilities. She confirmed she had not documented the response from any of the nursing facilities regarding the referrals sent out for Resident #1. She noted she did not know she had to document responses from referrals and was not aware she had to document everything that was done for a resident's discharge planning process in the medical record. She confirmed that none of the facilities had accepted Resident #1 until March 2023 and that she waited until he was accepted by another nursing facility to fill out a Discharge Assessment Guide and plan the discharge on 3/1/23. An interview on 5/11/23 at 10:00 AM, with the Director of Nursing (DON) revealed she was not involved in a care plan meeting regarding the discharge plan of Resident #1 and was not aware of any documentation regarding the discharge plan from Social Services. The DON noted there	F 660	• Corrective action completion date: June 25, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 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
F 660	Continued From page 4	F 660		

was no nursing documentation related to discharge planning.

An interview on 5/11/23 at 10:30 AM, with the Administrator confirmed Social Services had not documented regarding the discharge planning process for Resident #1 and there had not been an interdisciplinary approach for the discharge plan for Resident #1. The Administrator confirmed that there was no discharge care plan updated for Resident #1 and Social Services did not follow the discharge planning process for Resident #1.

Record review of the "Departmental Notes," for Resident #1, revealed there was no documentation regarding an interdisciplinary team meeting for discharge planning for Resident #1.

Record review of the "Discharge Assessment Guide and Plan," dated 3/1/23, for Resident #1 revealed " ... Special Instructions: DC (Discharge) to (Proper name of a facility). ... Community Agencies to Be Contacted: (Proper Name of facility) to follow up referral." Documentation revealed that the "Discharge Assessment Guide and Plan" was not fully completed.

Record review of the Physician's Orders dated 3/8/23 revealed an order "Discharge to (Formal name of nursing facility) on 3/9/2023..."

Record review of the Face Sheet for Resident #1 revealed an admission date of 3/22/22, with a diagnoses that included Nicotine Dependence, Cigarettes, Uncomplicated.

Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	**1301 BELK BOULEVARD OXFORD, MS 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
F 660	Continued From page 5 03/06/2023, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #1 is cognitively intact.	F 660		