

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 07/14/2026	
NAME OF PROVIDER OR SUPPLIER OXFORD HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 four (4) Complaint Investigations (CI MS # 2985700, CI MS #2998051, CI MS #3008252, and CI MS #3074799) at the facility from 7/13/26 through 7/14/26. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. F 602 was cited related to misappropriation of resident funds for CI MS #3074799 and F 656 was cited related to failure to develop a comprehensive care plan for CI MS #2998051. There were no citations for CI MS # 2985700 or CI MS #3008252. Census at the time of the survey was 95 with a bed capacity of 120 beds.			F0000			
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 and resident interview, record review, and facility policy review the facility failed to protect resident property from misappropriation for one (1) of three (3) residents reviewed for misappropriation when a housekeeping employee took the resident's debit card from his room and used it to make unauthorized purchases. Resident #2 Findings included: A record review of the facility policy, titled, "Abuse, Neglect and Exploitation", revealed "Policy: This facility's policy is to protect each resident's health,			F0602			

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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F0602 SS = D	Continued from page 1 welfare and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property..." A record review of the facility's investigation revealed that on 7/9/26, the Social Worker (SW) was notified that Resident #2 reported his debit card was missing. The SW interviewed the resident, who stated unauthorized charges had been made to his account. With the resident's permission, staff searched his room but were unable to locate the debit card. The resident contacted his financial institution and was informed the card had been used the previous day at a local gas station and grocery store. A police report was filed, and the bank stopped the pending transactions. On 7/10/26, law enforcement provided surveillance photographs from the grocery store identifying Housekeeper #1, an employee of the facility's contracted housekeeping services provider, as the individual using the resident's debit card. The contracted employee was immediately terminated, law enforcement continued its criminal investigation, and the facility re-educated all employees and contracted staff regarding abuse, neglect, and misappropriation of resident property. During an interview on 7/14/26 at 11:00 AM, Resident #2 confirmed his debit card had been taken from his room and used without his permission at a local gas station and grocery store for purchases totaling \$181.51. Observation of the surveillance photographs with the Director of Nursing on 7/14/25 at 11:15 AM, she confirmed the individual depicted using the resident's debit card was Housekeeper #1. An interview with the Housekeeping Supervisor confirmed that Housekeeper #1's employment was terminated immediately after she was identified as the perpetrator. A record review of the "Admission Record" revealed the facility admitted Resident #2 on 6/5/25, with diagnoses including type II diabetes mellitus and morbid obesity, A record review of the Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 6/3/26 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating that he was cognitively intact.			F0602			

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F0656 SS = D	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 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:	F0656					

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F0656 SS = D	Continued from page 3 Based on record review, staff interview and facility policy review, the facility failed to develop a comprehensive, person-centered care plan for a resident having multiple significant skin conditions requiring ongoing assessment and treatment for one (1) of three (3) residents reviewed for wound care. Resident #1 Findings included: Record review of the facility policy, titled, "Comprehensive Plan of Care", revealed "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality..." Record review of the "Wound Care Note", dated 1/14/26 revealed that upon admission, Resident #1 was identified as having a deep tissue injury to the left heel that was present on admission and a callus to the left great toe. Record review of the "Wound Care Note", dated 2/4/26 revealed that Resident #1 developed moisture-associated skin damage (MASD) to the sacrum. Record review of the "Wound Care Note", dated 2/11/26 revealed that Resident #1 developed an unstageable pressure ulcer to right upper sacrum. A record review of Resident #1's comprehensive care plan revealed no care plan addressing the resident's wounds, pressure injuries, skin impairment, repositioning needs, pressure-relieving devices, treatment regimen, despite the multiple clinically significant skin conditions and ongoing wound management. During an interview on 7/14/26 at 10:00 AM, the Minimum Data Set (MDS) Nurse stated the purpose of the comprehensive care plan was to provide an accurate picture of the residents' needs and guide staff in providing individualized care. She confirmed the resident did not have a care plan addressing any of his wounds or skin conditions and acknowledged that one should have been developed. During an interview on 7/14/26 at 10:15 AM, the			F0656			

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F0656 SS = D	Continued from page 4 Director of Nursing (DON) stated it was the facility's expectation that residents with wounds and skin impairments would have individualized care plans developed to direct their care. She acknowledged that Resident #1 should have had a comprehensive care plan addressing his wounds and skin conditions. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 1/14/26, with a diagnosis including Cerebrovascular Accident (CVA) and discharged him to the hospital on 2/17/26.			F0656			