

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255181		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER GLEN OAKS NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 55 SUSANNE STREET , LUCEDALE, Mississippi, 39452			
(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 #3119826 at the facility from 7/28/26 through 7/30/26. The SA investigated CI MS #3119826, quality of care related to treatment, and there were no citations related to the complaint investigation. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F628, F656, F658, and F836. The facility had a census of 35 and was licensed for 45 beds.		F0000				
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		F0628				

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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F0628 SS = D	Continued from page 1 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 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.	F0628					

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F0628 SS = D	Continued from page 2 §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 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	F0628					

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F0628 SS = D	Continued from page 3 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- (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.	F0628			

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F0628 SS = D	Continued from page 4 (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 interview, record review, and facility policy review, the facility failed to provide the resident representative with written notice containing the required transfer information when the resident was transferred to the hospital with return anticipated for one (1) of two (2) residents reviewed for hospitalization. (Resident #38). Findings include: A review of the facility's policy, "Transfer or Discharge Notice" revised November 2023, revealed, "...Policy Interpretation and Implementation...5. The resident and representative will be notified in writing of the following information. a. The specific reason for the transfer or discharge. f. The effective date of the transfer. g. The location to which the resident is being transferred or discharged..." A record review of the facility's "Admission Record" revealed the facility admitted Resident #38 on 06/15/2026 with diagnoses including Respiratory Failure, Unspecified with Hypoxia. A record review of the Discharge Return Anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/14/26 revealed Resident #38 was discharged to a short-term general hospital with return anticipated. A record review of the Admission MDS with an ARD of 06/22/2026 revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A record review of the "Order Details" revealed a physician order dated 07/14/26 for "D/C (discharge) to (proper name of local hospital)". A record review of Resident #38's medical record failed to identify documentation that the resident representative received the required written transfer notice containing the reason for the transfer, the effective date of the transfer, and the location to which the resident was transferred on 7/14/26. On 07/29/26 at 2:11 PM, during an interview, the Business Office Manager (BOM) acknowledged she did not provide the resident representative with a	F0628					

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F0628 SS = D	Continued from page 5 written transfer notice when Resident #38 was transferred to the hospital on 07/14/26. The BOM explained she believed the resident was being discharged rather than transferred with return anticipated. The BOM stated she would verify a resident's discharge status before issuing future transfer notifications. On 07/29/26 at 2:16 PM, during an interview, the Administrator acknowledged the resident representative did not receive a written transfer notice for Resident #38's hospitalization on 07/14/26. The Administrator confirmed the facility expected written transfer notifications to be provided to the resident representative each time a resident was transferred to the hospital.	F0628					
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.	F0656					

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F0656 SS = D	Continued from page 6 (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, staff interviews, record review, and facility policy review, the facility failed to develop and implement comprehensive person-centered care plans, as evidenced by failing to develop a comprehensive care plan for a resident with an active urinary tract infection (UTI) (Resident #27) and failing to implement an existing comprehensive care plan for oxygen therapy (Resident #28) for two (2) of (12) residents reviewed for comprehensive care planning. Findings include: A review of the facility's policy titled, "Using the Care Plan" revealed, "The care plan shall be used in developing the residents daily care routines and will be available to staff personnel who have the responsibility for providing care to the resident..." Resident #27 A record review of the "Admission Record" revealed the facility initially admitted Resident #27 on 10/21/2015 and she was readmitted on 7/22/26. She had diagnoses including Type 2 Diabetes Mellitus and UTI. A record review of the "Patient Visit Information" revealed Resident #27 was evaluated at a local hospital on 07/22/26 and received patient instructions for "Female Urinary Tract Infection" with a prescription for Cephalexin 500 milligrams (mg) four (4) times daily. A record review of the "Order Summary Report" revealed Resident #27 had a Physician's Order, dated 7/23/26, for Cephalexin 500 mg four times			F0656			

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F0656 SS = D	Continued from page 7 daily for ten (10) days. A review of the comprehensive care plan for Resident #27 revealed there was no designated care plan with interventions related to the new diagnoses of UTI. On 07/29/2026 at 2:35 PM, in an interview with Registered Nurse (RN) #1, she explained that the floor nurses are responsible for inputting care plans for new physician orders. She reported Medical Records reviews the physician orders daily and makes sure the physician orders are added as an intervention, but it was ultimately her responsibility to make sure care plans are developed. RN #1 confirmed that Resident #27 returned from the hospital on 7/22/26 and had orders for antibiotics and a diagnosis of UTI. She also confirmed there was no care plan developed with a problem or focus of UTI. She explained that she expected a comprehensive care plan to be developed for a new diagnosis, which would include a focus, goal, and interventions. On 07/29/2026 at 3:10 PM, in an interview with the Director of Nursing (DON), he stated he expected a care plan to be developed for residents with new diagnoses to include interventions for staff to follow to take care of residents. Resident #28 A record review of the "Care Plan Report" for Resident #28 revealed interventions included "Oxygen at 3 L (liters) per NC (nasal cannula) to maintain O2 (oxygen) > (greater than) 92%. Obtain O2 sat every shift" with a start date of 2/25/2026. On 07/28/26 at 3:39 PM, during an observation, Resident #28 was receiving oxygen via nasal cannula at (2) liters per minute. On 07/29/26 at 2:50 PM, during an observation, Resident #28 continued to receive oxygen via nasal cannula at two (2) liters per minute. On 07/29/26 at 2:54 PM, during an interview, Licensed Practical Nurse (LPN) #1 confirmed Resident #28 was receiving oxygen at (2) liters per minute. LPN #1 reviewed the physician order and confirmed the prescribed oxygen flow rate was three (3) liters per minute. LPN #1 acknowledged there was no physician order authorizing the lower oxygen flow rate and could not explain the discrepancy. On 07/29/26 at 2:55 PM, during an interview,			F0656			

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F0656 SS = D	Continued from page 8 Registered Nurse (RN) #1 confirmed the purpose of the comprehensive care plan was to guide staff in providing resident care. RN #1 confirmed staff were expected to implement the interventions contained in the comprehensive care plan. On 07/30/26 at 1:01 PM, during an interview, the Administrator confirmed staff were expected to verify oxygen flow rates, follow physician orders, notify the physician of discrepancies, monitor residents receiving oxygen therapy, and implement the resident's comprehensive care plan. A record review of the "Admission Record" revealed the facility admitted Resident #28 on 02/25/26 with diagnoses including Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. A record review of the "Order Summary Report" for Resident #28 revealed orders for oxygen at (3) liters per minute via nasal cannula, dated 3/9/26. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/2/2026 for Resident #28 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.			F0656			
F0658 SS = D	Services Provided Meet Professional Standards 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, interview, record review, and facility policy review, the facility failed to provide care and services in accordance with physician orders by administering oxygen at a flow rate different from the physician-ordered oxygen therapy for one (1) of (1) resident reviewed for oxygen therapy. (Resident #28). Findings include: A review of the facility's policy titled, "Oxygen Administration" revised October 2010, revealed "...The purpose of this procedure is to provide guidelines for safe oxygen administration...review physician orders...for oxygen administration..."			F0658			

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F0658 SS = D	Continued from page 9 A review of the facility's policy titled, "Conformity with laws and Professional Standards" revised April 2007, revealed "Our facility operates and provides services in compliance with... professional standards of practice that apply to our facility and types of services provided..." During an observation on 07/28/26 at 3:39 PM, Resident #28 was receiving oxygen via nasal cannula at two (2) liters per minute. During an observation, on 07/29/26 at 2:50 PM, Resident #28 continued to receive oxygen via nasal cannula at (2) liters per minute. During an interview on 07/29/26 at 2:54 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #28 was receiving oxygen at (2) liters per minute. LPN #1 reviewed the physician order and confirmed the prescribed oxygen flow rate was three (3) liters per minute. LPN #1 acknowledged there was no physician order authorizing the lower oxygen flow rate and could not explain the discrepancy. During an interview on 07/30/26 at 1:01 PM, the Administrator confirmed staff were expected to verify oxygen flow rates, follow physician orders, notify the physician of discrepancies, and monitor residents receiving oxygen therapy. A record review of Resident #28's "Medication Administration Record" (MAR) for July 2026 revealed staff documented oxygen was administered at three (3) liters per minute on 07/28/26 and 07/29/26, the same dates Resident #28 was observed receiving oxygen at (2) liters per minute. A record review of the "Admission Record" revealed the facility admitted Resident #28 on 02/25/26 with diagnoses including Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. A record review of the "Order Summary Report" for Resident #28 revealed a physician order dated 03/09/26 for oxygen at three (3) liters per minute via nasal cannula. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/2/2026 for Resident #28 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.			F0658			

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F0836 SS = D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to comply with state nursing facility staffing requirements by failing to designate a charge nurse responsible for supervision of the total nursing activities in the facility during the hours of 3:00 PM to 11:00 PM shift, separate from the medication/treatment nurse assignment for three (3) of (3) shifts reviewed for charge nurse supervision. Findings include: A review of the facility's policy titled, "Staffing," revised April 2007, revealed, "...Policy Interpretation and Implementation 1. Our facility maintains	F0836					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255181		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER GLEN OAKS NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 55 SUSANNE STREET , LUCEDALE, Mississippi, 39452			
(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
F0836 SS = D	Continued from page 11 adequate staffing on each shift to ensure that our resident's needs and services are met..." A record review of the "Staff Reporting Form" revealed there was not a designated charge nurse assigned for the 3:00 PM to 11:00 PM shift on 07/28/26, 07/29/26, or 07/30/26. A record review of the "Minimum Standards for Institutions for the Aged or Infirm" for Rule 45.4.1 Nursing Facility, revealed, "...To be classified as a facility, the institution shall comply with the following staffing requirements...2. Each facility shall have the following licensed personnel as a minimum....D. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse..." On 07/29/26 at 3:22 PM, during an interview, the Director of Nursing (DON) stated he served as the charge nurse from 7:00 AM until approximately 4:30 PM on some days. The DON explained that after 4:30 PM, the medication/treatment nurses also served as the charge nurses. The DON acknowledged the facility did not designate a separate charge nurse from the medication/treatment nurse role. The DON further acknowledged he was unaware the Minimum Standards for Institutions for the Aged or Infirm required a designated charge nurse separate from the medication/treatment nurse assignment for the 3:00 PM through 11:00 PM shift. On 07/29/26 at 3:30 PM, during an interview, the Administrator confirmed the medication/treatment nurses also served as the charge nurses during the 3:00 PM to 11:00 PM shift. The Administrator acknowledged the purpose of a separate charge nurse was to provide supervision of nursing services while allowing the medication/treatment nurse to focus on medication administration and treatments.			F0836			