

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 09/16/2026	
NAME OF PROVIDER OR SUPPLIER GLEN OAKS NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 55 SUSANNE STREET , LUCEDALE, Mississippi, 39452			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #3193347) at the facility from 9/14/26 through 9/16/26. CI MS #3193347 was a facility reported incident (FRI) regarding resident abuse. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and cited F600. Based on the facility's implementation of corrective actions on 9/13/26, the SA determined the deficiencies to be Past Non-Compliance (PNC), prior to the SA's entrance on 9/14/26. The facility held a license for 45 beds, with a census of 38.			F0000			
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to protect a resident's right to be free from physical and verbal abuse when a Certified Nurse Aide (CNA) continued to provide care after the resident repeatedly refused care and told the CNA to leave			F0600	"Past Noncompliance - no plan of correction required"		

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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F0600 SS = G	Continued from page 1 the room, resulting in a physical and verbal altercation during which the resident sustained multiple skin lacerations and bruising for one (1) of six (6) residents reviewed for abuse. Resident #1. Findings include: A record review of the facility's policy titled "Abuse Prevention Program", revised December 2016, revealed, "Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms...Policy Interpretation and Implementation: 1. Protect our residents from abuse by anyone including...facility staff..." A record review of the facility's policy titled "Resident Rights", revised December 2016, revealed, "Policy Statement: Employees shall treat all residents with kindness, respect, and dignity...Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect..." A record review of the facility's policy titled "Preventing Resident Abuse", revised August 2019, revealed, "Policy Statement: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse...Policy Interpretation and Implementation: 1. The facility's goal is to achieve and maintain an abuse-free environment..." A record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 01/19/2026 with the initial admission date on 12/29/2025 with diagnoses including Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, and Unspecified Cirrhosis of Liver. A record review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating her cognition was intact. A record review of the facility incident report dated	F0600					

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F0600 SS = G	Continued from page 2 09/09/2026 at 6:42 PM, revealed the facility documented an incident that involved Certified Nurse Assistant (CNA) #1 and Resident #1. While the nurse was providing care in another resident's room, CNA #1 approached the nurse and reported that Resident #1 had "beat her" and that she was "not taking that from anyone." The nurse attempted to obtain additional information from CNA #1; however, CNA #1 clocked out and left the facility before providing further information regarding the incident. The Director of Nurses (DON) was immediately notified, and nursing staff assessed Resident #1. Upon entering Resident #1's room, staff observed the resident's personal belongings scattered throughout the room. Resident #1 was partially dressed and seated in her wheelchair. Blood was observed on the bed, floor, and table, and Resident #1 was crying. Resident #1 informed the nurse that CNA #1 had hit her and pulled her off the bed. Resident #1 reported that she had told CNA #1 that she did not want CNA #1 to provide her care; however, CNA #1 responded "well you have me" and proceeded to attempt to change the resident. A head-to-toe assessment of Resident #1 revealed four skin lacerations following the incident: two to the right arm/hand area, one to the left hand, and one to the left lower extremity. Wound care was provided. The DON, Administrator, medical provider, Resident Representative (RR), and local police department were notified of the incident. The medical provider ordered Resident #1 to remain in the facility with continued monitoring and to be transferred to the emergency room for any acute change in condition. A record review of the facility-reported incident and SA observation of the facility's video camera footage revealed that on 09/09/2026 at 6:42:51 PM, CNA #1 entered Resident #1's room. Resident #1 was heard telling CNA #1 that she did not want CNA #1 to assist her. CNA #1 was heard responding, "I'm all you got" and "I'm the only one here." From approximately 6:44 PM through 6:45 PM, Resident #1 was heard repeatedly screaming, "Get out" and "Help." At 6:46:23 PM, CNA #2 was observed entering Resident #1's room. CNA #1 was then observed exiting the room while Resident #1 was heard yelling, "She's hitting, punching, and fighting me the whole time." After exiting the room, CNA #1 was heard reporting that Resident #1 had been fighting, hitting, and pinching her and stating, "She hit me with the f...ing call light." CNA #1 was also heard stating to Resident #1, "I had to roll you over so I could clean your ass." CNA #2 immediately obtained assistance. Resident #1 was subsequently observed sitting on the side of the bed. The facility terminated CNA #1 on 09/10/2026.			F0600			

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F0600 SS = G	Continued from page 3 A record review of the "Weekly Body Audit," dated 09/10/2026 at 9:30 AM, revealed Resident #1 was assessed following the incident. The assessment identified multiple areas of injury, including a 2 centimeter (cm) x 2 cm laceration to the left hand; bruising extending from the left hand to the left forearm measuring 15 cm x 12 cm; bruising to the left upper arm measuring 1.5 cm x 1.5 cm; multiple areas of bruising to the left upper lateral back; redness to the middle of the back measuring 8 cm x 10.5 cm; a 2 cm x 2 cm laceration to the left leg; bruising to the right upper arm measuring 1.5 cm x 1.5 cm; a laceration to the right hand measuring 1.5 cm x 0.5 cm; three lacerations to the right forearm; and bruising extending from the right hand to the right forearm measuring 17.5 cm x 10 cm. A record review of the local police department incident report, dated 09/09/2026 at 8:41 PM, identifying CNA #1, revealed "Offense information, Vulnerable Person, Abuse or Neglect of...Attempted? No" A record review of the Nurse Practitioner-Psychiatric (NP-P) "Progress Note" dated 09/13/2026 revealed, Resident #1 was evaluated on 09/13/2026 for psychiatric follow-up visit related to incident involving allegations of abuse. She denies nightmares, recurrent or distressing dreams, intrusive recollections, avoidance related to the incident, hypervigilance, or exaggerated startle response. She denied acute emotional distress and reported that she had been doing okay since the incident. The resident presented with improved mood and mild situational anxiety related to the reported incident and trauma related symptoms were assessed. She reports feeling safe and no acute psychiatric decompensation, psychotic symptoms, or significant depressive symptoms noted. On 09/14/2026 at 11:15 AM, during an interview, CNA #2 stated on 09/09/2026 at approximately 6:30 PM, she was going to assist CNA #1 with her last rounds when she heard Resident #1 screaming, "Help." CNA #2 immediately went to Resident #1's room and observed CNA #1 walking out of the room. CNA #1 told CNA #2 that Resident #1 had been hitting her with the call light and screaming that she did not need CNA #1's help. CNA #2 immediately reported the incident to Licensed Practical Nurse (LPN) #1. CNA #2 returned to Resident #1's room and assisted the resident from the bed to her wheelchair. CNA #2 reported that she initially observed no blood; however, she observed items from the resident's bedside table scattered on the			F0600			

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F0600 SS = G	Continued from page 4 floor. CNA #2 reported that Resident #1 had yelled out on previous occasions when she did not want certain staff members providing her care. CNA #2 further reported that she had never observed CNA #1 being unkind or disrespectful toward residents or staff. On 09/14/2026 at 2:00 PM, during an interview, Resident #1 recalled the incident involving CNA #1. Resident #1 stated that CNA #1 "had a smart mouth," and she threw her call light at CNA #1. Resident #1 reported CNA #1 told her she needed to provide peri-care because she had a bowel movement. Resident #1 confirmed she screamed "Help" and "Get out" and swung at CNA #1 to defend herself. Resident #1 further reported that CNA #1 hit and punched her. During the interview, the State Agency (SA) observed healing skin tears and areas of healing bruising to Resident #1's upper arms. Resident #1 confirmed that she had no fear of remaining at the facility since CNA #1 was no longer present in the facility. On 09/14/2026 at 3:01 PM, during an interview, LPN #1 stated that on 09/09/2026, she was in another resident's room and did not hear screaming. When she entered the hallway, she observed CNA #1 upset and reporting that Resident #1 "beat my ass." CNA #1 refused to complete an incident report, clocked out, and exited the facility. LPN #1 stated CNA #2 assisted Resident #1 into her wheelchair. Resident #1 was crying, her belongings from the bedside table were scattered on the floor, and blood was observed on the resident's bed and floor. LPN #1 stated she assisted with calming Resident #1, completed an assessment, and immediately notified the Director of Nurses (DON). LPN #1 stated she observed no bruising or bleeding on CNA #1. The medical provider and Resident Representative (RR) were notified following the assessment, and LPN #1 was instructed to monitor the resident and transfer the resident to the local emergency department for any change in condition. On 09/15/2026 at 4:00 PM, during an interview, the Psychiatric Nurse Practitioner (NP-P) stated that she evaluated Resident #1 on 09/13/2026 following the incident. The NP-P reported that Resident #1 demonstrated no symptoms of post-traumatic stress or acute emotional distress, although mild situational anxiety related to the incident was noted. Resident #1 reported sleeping well, denied nightmares, and reported feeling safe at the facility. On 09/15/2026 at 5:00 PM, during an interview, CNA #1 confirmed that she made a mistake by continuing			F0600			

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F0600 SS = G	Continued from page 5 to provide care after Resident #1 began yelling and that she should have immediately exited the room and notified the nurse. CNA #1 reported that Resident #1 was soiled with a bowel movement and that while providing peri-care and assisting the resident onto her side, she used one hand to hold the resident while cleaning her. CNA #1 reported that Resident #1 repeatedly hit her with the call light and continued screaming. CNA #1 reported that after completing the care, she exited the room and became upset, clocked out, and left the facility. She returned the following morning and was terminated related to the incident. CNA #1 denied hitting Resident #1, holding her down, or intentionally causing the resident pain. On 09/16/2026 at 10:00 AM, during an interview, the Director of Nurses (DON) revealed that prior to the incident, CNA #1 had a good reputation at the facility and there had been no previous complaints or concerns regarding CNA #1 being mean, disrespectful, or abusive toward residents. The DON confirmed that staff are expected to respect a resident's refusal of care and, if a resident becomes combative or the situation escalates, staff should stop care, leave the room, notify the nurse, and obtain assistance. The DON reported that CNA #1 should have discontinued care when Resident #1 repeatedly told her to get out and began yelling for help. The DON confirmed that the facility's investigation identified injuries to Resident #1 following the incident and that CNA #1 was terminated from employment on 09/10/2026. The DON confirmed that the facility expects all residents to be protected from abuse and treated with dignity and respect. On 09/16/2026 at 10:30 AM, during an interview, the Administrator revealed that immediately following the incident, the facility initiated its abuse investigation and reported the allegation to the State Agency, Attorney General's Office, and local police department. The Administrator confirmed that all residents assigned to CNA #1 were immediately assessed, with no additional concerns identified. The Administrator reported that facility-wide in-services regarding abuse prevention, resident rights, and reporting requirements were initiated for all staff. An emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted to review the incident and implement corrective actions. The Administrator confirmed that CNA #1 was removed from resident care and subsequently terminated from employment. The Administrator reported that the facility expects all staff to protect residents from abuse and immediately report any			F0600			

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F0600 SS = G	Continued from page 6 allegation or suspected abuse. Following the incident, the QAPI Committee held an emergency meeting to review the incident and initiate corrective actions. Beginning on 09/09/2026, all supervisors initiated facility-wide staff training on Corporate Compliance, Abuse (Hand in Hand), Legal Duty of Reporting Elder/Dependent Abuse, What is Abuse, Preventing Abuse, Abuse and Exploitation, and Recognizing and Addressing Burnout, with training completed on 09/11/2026. On 09/11/2026, the Resident Council held an emergency meeting addressing abuse, resident rights, and reporting abuse. Beginning on 09/09/2026, the facility initiated monitoring to include interviews with five staff members five days per week for eight weeks, and beginning on 09/10/2026, the DON initiated observations of staff interactions and interventions with three residents five days per week for eight weeks. Findings from the monitoring will be reported to the QAPI Committee for two months. On 09/09/2026, CNA #1 was placed on administrative leave pending investigation and was terminated from employment on 09/10/2026 for verbal abuse. The facility notified the Mississippi State Department of Health and local police department by telephone on 09/09/2026 and notified the Attorney General's Office in writing on 09/10/2026. Validation: The SA validated on 09/16/2026 through interview and record review, that all corrective actions had been implemented as of 09/13/2026 and the facility was in compliance, prior to the SA's entrance on 09/14/2026.			F0600			