STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 1/2/24-1/4/24. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. The SA cited M610, M625, M630, M640, M655 and M780. The census at the time of the survey was 76 and the facility is licensed for 120 beds.	M 000		
M 610 SS=D	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to provide care to maintain hygiene as evidenced by failure to provide facial cleaning for Resident #30, nail care for Resident #47, shaving for Resident #59, and provide showers, shaving, and nail care for Resident #60 and Resident #67 for five (5) of the	M 610	1. On 1/3/2024, resident number 60 was provided with bathing and nail care. On 1/3/2024, resident number 67 was provided a bath, shaven and provided nail care. On 1/4/2024, resident number 59's facial hair was removed. On 1/3/2024, resident number 30's face and mouth was cleaned. On 1/3/2024, resident number 47 was bathed and provided nail care.	1/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 1 21 residents reviewed. Findings include: Review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" with a revised date of March 2018, revealed, "Policy Statement Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." Review of the facility policy titled, "Shaving the Resident" with a revised date of February 2018, revealed, "The purpose of this procedure is to promote cleanliness and to provide skin care... Documentation The following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual(s) who performed the procedure..." Review of the facility policy titled, "Fingernails/Toenails, Care of" with a revised date of February 2018, revealed, "The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...Documentation, The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual(s) who administered the nail care..." Resident #60 An observation and interview on 01/02/24 at	M 610	2. All resident's that require assistance with ADL care have the potential to be affected. 3. On 1/8/2024, in-service was provided to all Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants on providing ALD care to include bathing, shaving, and providing nail care by Staff Development Coordinator nurse. 4. Beginning on 1/8/2024, Assistant Director of Nursing or Director of Nursing will observe resident's to ensure they are receiving a bath, nail care, shaving and facial cleaning five times a week for 4 weeks, then two times a week for 4 weeks, then weekly times 3 months. Assistant Director of Nursing or Director of Nursing will bring results of the audit to monthly Quality Assurance/Performance Improvement meeting for 5 months 1/25/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 2 12:40 PM, Resident #60's facial hair was approximately one-half (1/2) inch long on his chin, above his lip, and on the sides of his face. Fingernails on bilateral hands were approximately ½ inch long and jagged past the tips of his fingers. Resident #60 revealed he likes to be shaved but likes to keep his mustache. He revealed they have to do it for him. Resident #60 revealed he doesn't think he got a shower yesterday and thinks the last time was on Friday. An observation on 01/02/24 at 4:00 PM, Resident #60 lying in bed with no change in appearance. An observation and interview on 01/03/24 at 9:25 AM, Resident #60 with no change in appearance as the day before. Resident #60 revealed he hasn't been up yet and hasn't had a shower or been shaved. Nails on bilateral hands remained ½ inch long and jagged past the tips of his fingers. An interview and observation on 01/03/24 at 10:56 AM, Resident #60 revealed they shaved me, but it's not done right. Facial hair was noted approximately 1/4 inch long on his chin and sides of his face. He stated, "I still haven't had a shower." An interview and observation on 01/03/24 at 11:08 AM, Certified Nurse Aide (CNA) #3 revealed she was assigned to the Resident #60 today and she shaved him just a bit ago. She confirmed that he still had facial hair. She confirmed his nails were long and jagged and revealed she wasn't sure when he last got a shower because she wasn't here yesterday. An interview and observation on 01/03/24 at 11:13 AM, the Director of Nurses (DON)	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 3	M 610		

confirmed that Resident #60 needed to be shaven, and his nails were long on both hands and needed to be trimmed. The DON revealed the resident sometimes refuses and it is in his care plan. Resident #60 revealed he hadn't had a shower and the DON stated, she wasn't sure why he didn't get shaven or a shower since his shower days are Tuesday, Thursday, and Saturday.

An interview on 01/03/24 at 11:30 AM, the treatment nurse revealed that she or any of the floor nurses do nail care for the residents that are diabetic. She confirmed that Resident #60 is diabetic, and his nails were long and jagged, she wasn't sure when his nails were last done. She revealed when they do nail care there is nowhere to document that the task has been completed so there is nothing to look back on to see when or who did it last. She revealed that his nails being long and jagged could create a skin tear and then possible infection.

Record review of Resident #60's Admission Record revealed the resident was admitted to the facility on 08/18/2022 with medical diagnoses that included Type 2 Diabetes Mellitus and Cerebral Infarction.

Record review of Resident #60's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of Oct 30, 2023, revealed under section C a Brief Interview for Mental Status (BIMS) score of 10, which indicates the resident has moderate cognitive impairment.

Resident #67

An observation and interview on 01/02/24 at 12:30 PM revealed Resident #67 with facial hair approximately ½ inch long to his chin and sides of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 4	M 610		

his face and the fingernails on his right hand were approximately one (1) inch long and jagged past the tips of his fingers. His left-hand fingernails were trimmed. Resident #67 revealed he doesn't remember when his fingernails were trimmed and why the right hand was not trimmed as well. He revealed he likes for all his nails to be trimmed, not just one hand. Resident #67 revealed he usually gets shaven when he gets a shower and the last time, he was showered was last week. He revealed the girl didn't come around yesterday to do it.

An observation on 01/02/24 at 03:50 PM revealed Resident #67's appearance remains unchanged as evidenced by unshaven facial hair and nails long and jagged on his right hand.

An observation and interview on 01/03/24 at 9:15 AM revealed Resident #67's appearance unchanged from the previous day. Resident #67 stated he didn't get cleaned up yesterday or shaven.

An observation and interview on 01/03/24 at 10:50 AM, with CNA#3 and Resident #67 revealed Resident #67 with no facial hair and neatly shaven. His fingernails on his right hand remained long and jagged approximately 1 inch past his fingertips. CNA #3 revealed she shaved him a little bit ago because she noticed that he needed to be shaven, but she wasn't sure about when he last had a shower. Resident #67 revealed I haven't had a shower today; the last time I had a shower was last week. CNA #3 confirmed that the nails on his right hand were long and jagged and needed to be trimmed and revealed she wasn't sure why the left-hand fingernails were trimmed, and the right-hand fingernails were long.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 5 An interview and observation on 01/03/24 at 11:20 AM, with the DON and Resident #67, the DON confirmed that Resident #67 is supposed to have his showers on Tuesday, Thursday, and Saturday, and that usually includes shaving as well. She revealed that the resident can accurately verbalize when he was last showered and shaven. Resident #67 confirmed to the DON that his last shower was last week, and he finally got shaved this morning. The DON confirmed that his fingernails were long on his right hand and needed to be trimmed. An interview and observation on 01/03/24 at 12:17 PM, the Treatment Nurse revealed the CNAs are responsible for the nail care for Resident #67 since he is not a diabetic. She revealed there is no way to look at any documentation to see when the task has been completed or when it is due to be done. She confirmed that Resident #67's fingernails were long and jagged on the right hand and could cause bacteria or a skin tear. Record review of Resident #67's Admission Record revealed the resident was admitted to the facility on 04/27/2023 with medical diagnoses that included Nontraumatic intracerebral hemorrhage, Chronic Kidney Disease, and Anemia. Record review of Resident #67's MDS with an ARD of 10/20/23, revealed under section C a BIMS score of 13, which indicates the resident is cognitively intact. Resident #59 During an observation and interview with Resident #59 on 1/2/24 at 10:30 AM, short white	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 6	M 610		

hair was noted to the left side of the resident's chin. She stated she wanted the hair removed, but the staff has not offered to do it.

An observation of Resident #59 on 1/3/24 at 8:45 AM, revealed that the resident continued to have short white hair on the left side of her chin.

Upon interview with Certified Nursing Assistant #1 (CNA) on 1/3/24 at 12:00 PM, she stated facial hair is to be removed on the resident's shower day.

On 1/3/24 at 12:02 PM, Registered Nurse #1 (RN) stated that facial hair should be removed on the resident's shower day.

Record review of documented tasks revealed Resident #59 received a shower on 1/3/24.

On 1/3/24 at 12:05 PM, Resident #59 stated that staff did not offer to remove her facial hair during her shower.

During an interview with the DON on 1/4/24 at 9:35 AM, she verified that staff should have removed the resident's facial hair during her shower on 1/3/24.

A record review of Resident #59's Quarterly MDS with an ARD of 10/9/23 revealed a Brief Interview for Mental Status Score (BIMS) of 15 indicating that the resident is cognitively intact. Section GG, Physical Functioning Abilities, indicated that the resident is dependent for personal hygiene and showering.

A record review of the Admission Record for Resident #59 revealed that she was admitted to the facility on 8/4/22 with a diagnosis of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 7 Contracture to the left hand. Resident #30 An observation of Resident #30 on 01/03/24 at 8:01 AM, revealed he was sitting in a high back wheelchair in his room with a dry, crusty yellow substance surrounding his mouth and extending to his chin. The resident was non-verbal. An observation and interview with Licensed Practical Nurse (LPN) #3 on 01/03/24 at 8:10 AM, confirmed that Resident #30 had a dried substance around his mouth that extended to his chin. She revealed she was not sure what the substance was but stated it could be dried Ensure. She revealed that the resident had to be assisted out of bed by staff this morning and acknowledged that whoever assisted him up should have noticed the substance and washed his face. She confirmed that this was part of the daily care to ensure the resident was groomed appropriately, and his face was cleaned after meals and when needed. An observation and interview on 01/03/24 at 8:25 AM, with the DON confirmed the aides were responsible for ensuring the resident's face was clean after meals and when needed as part of grooming. Record review of the Admission Record for Resident #30 revealed the resident was admitted to the facility on 5/10/23 with medical diagnoses that included Hypotension, Gastro-Esophageal Reflux Disease without Esophagitis, and Unspecified Protein-Calorie Malnutrition. Record review of the MDS with an ARD of	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 8 12/16/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #30 is cognitively intact. Resident #47 An observation of Resident # 47 on 01/02/24 at 11:02 AM, revealed she was lying in bed with both hands contracted, all fingernails long, approximately 3/8 (three-eights) inch in length, with a black substance underneath, and strong musty body odor smell in the room. An observation and interview with Licensed Practical Nurse (LPN) #3 on 01/03/23 at 11:10 AM, confirmed that Resident # 47 had long fingernails with a black substance underneath. She revealed the resident's nails were causing marks inside the inner palms due to hand contractures. She revealed the nails needed clipping and cleaned. The aides were responsible for cleaning the nails daily and could cut them if the resident was not a diabetic. She revealed that long nails could cause skin injury and infection. She acknowledged that the resident had a strong body odor and revealed the aides may not be using deodorant. An interview with Certified Nurse Aide (CNA) #5 on 01/03/23 at 11:15 AM, revealed she was assigned to Resident #47 today. She confirmed that the resident had a strong body odor and said that she always does. An observation and interview with the DON on 01/03/23 at 11:30 AM, confirmed Resident #47's long nails. She revealed that the resident fights the staff, and they have been unable to trim them. She revealed the resident was care planned for refusal.	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 610	Continued From page 9 An interview with the DON on 01/03/23 at 12:20 PM, revealed that the facility does not have a task to prompt nail care and revealed that nail care was part of the bathing process for the aides to ensure the nails are clean and cut. She revealed the diabetics nails are cut by the nurses and can be done as needed. She revealed that Resident #47 should have a refusal care plan in place for nail care, and confirmed the resident did not. Record review of the Admission Record for Resident #47 revealed the resident was admitted to the facility on 9/06/20 with medical diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus, Contracture, right hand, and Gastrostomy Status. Record review of the MDS with an ARD of 12/05/23 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score was not conducted due to cognitive skills are severely impaired.	M 610		
M 625 SS=D	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatments and services to increase range of	M 625	1. On 1/3/2024, resident #51 and resident # 59 had splints placed as ordered. 2. On 1/8/2024, Licensed Practical Nurse Minimum Data Set nurse reviewed orders to identify any resident's that have an	1/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 625	Continued From page 10 motion and/or to prevent further decrease in ROM as evidenced by staff not applying hand splints and an elbow brace as ordered for two (2) of 25 sampled residents. Resident #51 and #59 Findings Include: Record review of a statement on facility letterhead, undated and signed by the Administrator revealed, "The facility does not have a policy that specifies who is responsible for donning/doffing splints or providing range of motion." Resident #51 Record review of the Order Summary Report with active orders as of 1/1/24 revealed an order effective 11/22/23 to monitor placement of left hand splint and elbow brace to be don before breakfast, to be doff after breakfast every day shift. On 01/03/24 at 8:15 AM, observed Resident #51 sitting up in his wheelchair in his room with breakfast tray on his bedside table. He was feeding himself with his right hand. He was unable to use his left arm and it was resting in his lap. Resident #51 was intermittently holding his left arm up with his right hand for support. There was no hand splint observed on his left hand and no brace supporting his left elbow. On 01/03/24 at 11:00 AM, observed Resident #51 propelling himself in his wheelchair down the hall and there was no left hand splint or elbow brace intact to his left upper extremity. He was supporting his left arm by holding it up with his right hand.	M 625	order for a splint to be placed. There were nine(9) resident's identified as having an order for splints. All resident's with an order for splints has the potential to be impacted. 3. An in-service was completed by the Director of Therapy regarding donning and doffing splints for all Registered Nurse's, LPN's, and Certified Nursing Assistant's on 1/3/2024. 4. Beginning 1/9/2024, RN MDS Coordinator or LPN MDS nurse will observe resident's with splint ordered to ensure resident has splints in place five times a week for four weeks, then 2 times a week for 4 weeks, then weekly times 3 months. RN MDS Coordinator or LPN MDS nurse will bring results of audits to monthly Quality Assurance/Performance Improvement for five months beginning 1/25/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 625	Continued From page 11 On 01/03/24 at 11:55 AM, an interview with Certified Nursing Assistant (CNA) #4, revealed that she was assigned to Resident #51 and was familiar with him. She revealed that she didn't know anything about an elbow brace or hand splint for Resident #51 and didn't know that he was supposed to wear them. On 01/03/24 at 2:10 PM, an interview with Occupational Therapy Assistant, (OTA), revealed that Resident #51 was no longer on their caseload and not receiving therapy services at this time. She revealed that his left arm had been really contracted when he first started here and it had been ordered for him to have an elbow brace and hand splint to be applied daily for a few hours. She revealed that the CNAs were the one's who applied braces and splints on the residents. The OTA revealed that Resident #51 was ordered to wear a hand splint and an elbow brace to his left arm to help prevent him from becoming more contracted. On 01/03/24 at 2:40 PM, an interview with Licensed Practical Nurse (LPN) #5, revealed that the Restorative Aide normally puts the braces and splints on the residents in the morning and takes them off after lunch. On 01/04/24 at 10:30 AM, an interview with Director of Nursing, revealed that the specific care ordered for the residents was on the computer system and that the CNAs should have seen that Resident #51's splint and brace were ordered and it should have been done. Record review of Resident #51's Admission Record revealed an admission date of 03/08/2021 and that he had the following	M 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 625	Continued From page 12	M 625		

diagnoses: Cerebral Infarction, Dysarthria following Cerebral Infarction, Unspecified Abnormalities of Gait and Mobility, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Need for Assistance with personal care, and Other reduced mobility.

Record review of Resident #51's Minimum Data Set (MDS) dated 11/18/2023 under Section C - Cognitive Patterns was documented a Brief Interview for Mental Status Score (BIMS) of 08 which indicated that he had moderate cognitive deficits.

Resident #59

A record review Resident #59's "Order Summary Report" with active orders as of 1/1/2024 revealed an order dated 12/1/2023"monitor placement of left hand pucci air hand brace, don before breakfast, remove after lunch.

An observation and interview with Resident #59 on 1/2/24 at 10:15 AM, revealed an order dated 12/1/23 a contracture to the left hand with no devices in place. Resident #59 stated that she did not receive splinting of any kind to her left hand.

An observation of Resident #59 on 1/3/24 at 11:40 AM, revealed no hand brace in place.

During an observation and interview with LPN #1 on 1/3/24 at 11:45 AM, she verified that the resident did not have a hand brace in place on her left hand, but it should have been on. LPN #1 was unable to locate the hand brace anywhere in the resident's room. She stated that the CNA was responsible for the application and removal of the hand brace, and the nurse was responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 625	Continued From page 13 monitoring that it was in place. During an interview with CNA #1 on 1/3/24 at 12:00 PM, she stated that she was aware that the resident wore a brace but that she was not responsible for applying it. CNA #1 stated that Therapy or Restorative was responsible for applying the brace. In an interview with the OTA on 1/3/24 at 1:15 PM, she stated that the resident was not currently on therapy caseload, therefore they were not responsible for applying the hand brace. The OTA verified that residents were to wear splints and braces to prevent them from becoming more contracted. During an interview on 1/3/24 at 1:48 PM, with the Director of Nursing she stated that the floor CNA was responsible for the application and removal of the hand brace. The DON verified that there was no documentation that the brace was applied. A record review of Resident #59's Quarterly MDS with an ARD of 10/9/23 revealed a BIMS score of 15 indicating that the resident is cognitively intact. Section GG, Functional Abilities and Goals indicated Resident #59 had functional limitation in the upper extremities. A record review of the Admission Record for Resident #59 revealed that she was admitted to the facility on 8/4/22 with diagnoses that included Contracture, left hand.	M 625		
M 630	45.21.6 Mental and psycho-social Mental and psycho-social. A resident who	M 630		1/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 630	Continued From page 14 displays adjustment difficulty receives appropriate treatment and services to address the assessed problem. This Statute is not met as evidenced by: Level II Based on staff interviews, record review and facility policy review the facility failed to deliver care and services for a resident with a diagnosis of Post traumatic stress disorder (PTSD) for one (1) of 25 sampled residents. Resident #26. Findings Include: Record review of the facility policy "Trauma-Informed and Culturally Competent Care" with a review date of January 2023 revealed "Purpose To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization ...." On 01/03/24 9:31 AM, during an interview Resident #26 revealed that the staff were taking care of him here, but he just had been through so much that he wanted to go home. He revealed that he came home from the Army to no home due to it burning down while he was gone. He stated, "I just want to go home." On 01/04/24 at 8:30 AM, an interview with the Social Worker (SW) revealed that she completed the Trauma Informed Care Assessment on every resident upon admission to the facility. She revealed that Resident #26 had been here for several years and that they should have gone back and completed the assessment but she was	M 630	1. On 1/5/2024, a trauma informed care assessment was completed for resident # 26 by social services director. 2. On 1/22/2024, Social Services reviewed all active resident's charts to ensure each resident had a trauma informed care assessment completed. All resident's in the facility have the potential to be impacted. 3. On 1/8/2024, Social Services was in-serviced by Administrator on facility policy for trauma informed care assessments. All Registered Nurses and Licensed Practical nurses were in-serviced on trauma informed care and identifying behaviors related to trauma by Staff Development Coordinator on 1/22/2024. 4. Beginning, 1/8/2024, the Administrator or Director of Nursing will review each new admits clinical records after admission to ensure resident has a trauma informed care assessment completed times three(3) months. The results of the audit will be brought to monthly Quality Assurance/Performance Impprovement meeting for 3 months beginning 1/25/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 630	Continued From page 15	M 630		

unable to find it. The SW stated, "It definitely should have been done."

On 01/04/24 at 10:00 AM, an interview with Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #2 confirmed that they were unable to find the Trauma Informed Care Assessment that should have been completed on Resident #26.

On 01/04/24 at 10:20 AM, an interview with LPN #6, revealed that he was assigned to Resident #26 and was familiar with him. LPN #6 revealed that Resident was often confused and was not aware that he had the diagnosis of Post Traumatic Stress Disorder. LPN #6 revealed that Resident #26 does better with men than with women and stated, "He likes me and I don't have any problems with him."

On 01/04/24 at 10:45 AM, an interview with Administrator revealed that a Trauma Informed Care Assessment should have been completed on Resident #26.

Record review of Resident #26's Admission Record revealed an admission date of 12/27/2017 with diagnoses that included Anxiety disorder, Unspecified Psychosis, and Other recurrent depressive disorders and PTSD.

Record review of Resident #26's "Medical Diagnosis" form revealed that he had the diagnosis of Post-Traumatic Stress Disorder effective 01/17/2019.

Record review of Resident #26's Minimum Data Set (MDS) dated 10/09/23 Section C - Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 630	Continued From page 16 Resident #26 was cognitively intact. Section I revealed that he had a PTSD diagnosis.	M 630		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to provide adequate supervision for residents who smoke as evidenced by failure to secure smoking materials for two (2) of 15 smokers residing in the facility. Resident #44 and #72 Findings Include: Review of the facility policy titled "Facility Smoking Policy-Supervised Smoking" with a revision date of 10/2022 revealed " ...THIS FACILITY IS A SUPERVISED SMOKING FACILITY All smoking in this facility is SUPERVISED and at designated times .... Staff will maintain/keep all smoking materials (e.g. cigarettes, pipes, matches. lighters. lighter fluid) and distribute the materials to residents at smoking times ...." Resident #44	M 640	1. On 1/3/2024, Administrator educated resident # 44 and resident # 72 on the facility's smoking policy. Both resident # 44 and resident # 72 turned their cigarettes and lighters into the Administrator to be placed in the smoking box at the nurses station. 2. On 1/3/2024, Administrator reviewed list of facility smokers and identified that all smokers have the potential to be impacted. 3. On 1/3/2024, Administrator educated each smoker on the facility smoking policy. Each smoker was asked to turn in their cigarettes and lighters to the Administrator to be placed in the smokers box. Each smokers responsible represenative was contacted and educated on 1/22/2024 by the Administrator on the facility smoking policy and asked to to bring any cigarettes or lighters to the resident's instead they need to be given to a nurse to be placed in the	1/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 640	Continued From page 17 An observation and interview with Resident # 44 on 01/02/24 at 10:54 AM revealed her lying in bed and observed with a pack of cigarettes. She revealed she always keeps her cigarettes on her or in the bedside drawer. The resident opened up the cigarette box to view inside the box and observed eleven (11) cigarettes with a black lighter. Record review of the Admission Record for Resident #44 revealed that the resident was admitted to the facility on 3/27/23 with medical diagnoses that included Unspecified Sequelae of Cerebral Infarction, Type 2 Diabetes Mellitus, Essential (Primary) Hypertension and Morbid Obesity. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/23 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident # 44 is cognitively intact. Resident #72 An observation on 01/03/24 at 3:10 PM, revealed Resident #72 propelling himself in a wheelchair inside the doorway from the outdoor smoking area. The resident was observed with a lighter in his hand. The resident propelled himself down to his room. An interview on 1/03/24 at 3:16 PM, with Resident # 72 revealed that he had just come inside from smoking. The resident revealed he went outside in the smoking area by himself and that he keeps his lighter and cigarettes on his person and smokes when he desires.	M 640	smoking box. 4. Beginning 1/8/2024, Administrator or Director of Nursing will observe smokers to ensure they don't have any cigarettes' or lighters five times a week for four weeks, then weekly times 3 months. Administrator of Director of Nursing will bring the results of the audit to monthly Quality Assurance/Performance Improvement meeting times 4 months beginning 1/25/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 640	Continued From page 18 Record review of the Admission Record for Resident #72 revealed the resident was admitted to the facility on 8/08/23 with medical diagnoses that included Cerebral Infarction, Type 2 Diabetes Mellitus, Alzheimer's Disease, Chronic Combined Systolic and Diastolic (Congestive) Heart Failure and Tobacco use. Record review of the MDS with an ARD of 11/11/23 revealed under section C, a BIMS score of 10, indicating Resident #72 is moderately cognitively impaired. An interview on 1/03/24 at 3:25 PM, with Licensed Practical Nurse (LPN) #4 revealed that all the smoking paraphernalia was kept in a plastic box at the nurse's desk. She revealed that they have one (1) to two (2) staff members that supervise the designated smoke breaks. She revealed the staff distributed two (2) cigarettes to the residents and the staff members were responsible for lighting them. She confirmed that Resident #44 having smoking paraphernalia on his person had been a concern for the facility, and stated she was "noncompliant." She revealed that the families or friends were bringing cigarettes and lighters to the residents, so it was challenging to keep track. She confirmed that allowing the resident to keep smoking paraphernalia could result in an accident or fire. An interview with the Administrator (ADM) on 1/03/24 at 3:35 PM, revealed that the facility did not have any independent smokers residing in the facility. He revealed that the facility policy stated smoking materials must be kept by staff, and they keep them at the nurse's station. He confirmed that adequate supervision must be provided during smoking to ensure resident safety, and residents having smoking materials on their	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 640	Continued From page 19 person places the facility at risk for fires. An interview with Certified Nurse Aide (CNA) #3 during a scheduled smoke break on 1/03/24 at 4:10 PM, confirmed that Resident # 44 and #72 had been a concern regarding keeping smoking materials on their person. She revealed none of the residents should have cigarettes or lighters and confirmed this was a hazard to the facility and could result in fire. An interview with the Director of Nursing (DON) on 1/4/24 at 8:40 AM revealed that she was aware of some residents keeping smoking materials on person. She revealed that she had educated all the smokers regarding the matter. She confirmed it had been an ongoing concern. She revealed that it's discussed in the morning meetings when it's observed, and she had made the Administrator aware. She revealed that the door that exits to the smoking pavilion was not kept locked, and acknowledged that this gave the residents free rein to go outdoors to smoke at liberty. An interview with the ADM on 01/04/24 at 8:45 AM, confirmed that residents keeping smoking paraphernalia and going outdoors to smoke with no supervision had been an ongoing concern for the facility. He revealed that at one point the residents were allowed to go outdoors and smoke independently, but they had a facility policy change a while ago requiring residents to now be supervised. He revealed that after the change, they met with all the smokers and notified them and mailed out a copy of the new smoking policy to the families.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 655	Continued From page 20	M 655		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to assess and provide the necessary adaptive equipment to a resident to promote independence for drinking for one (1) of two (2) residents reviewed for dining. Resident #30 Findings Include: Review of the facility policy titled "Assistance with Meals" dated 10/22 revealed under, "Policy Statement: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident...Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups..." An observation of Resident # 30 on 01/03/24 at 8:20 AM, revealed the resident was trying to drink thickened orange juice from a straw and unable to handle the cup and straw independently. The	M 655	1. On 1/8/2024, resident # 30 was evaluated by Occupational Therapist for an assistive device for drinking and was provided an adaptive cup. 2. On 1/8/2024, Administrator and Assistant Director of Nursing observed residents during meals to identify any resident's that needed assistance with meals or needed assistive devices. All resident's who receive meals have the potential to be affected. 3. On 1/8/2024, in-service was provided by Staff Development coordinator to all Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant's on assisting resident's during meals and identifying and reporting to therapy director if a resident appears to need any assitive devices for meals. 4. Beginning 1/9/2024, resident's will be observed during meals by Administrator or Assistant Director of Nursing five times a week for 4 weeks, then weekly for three months to ensure resident's that require assistance are receiving assistance and	1/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 655	Continued From page 21 straw would not stay inside the cup while the resident was trying to drink and hold the cup. No staff member was observed assisting with the breakfast meal. An observation and interview on 01/03/24 at 8:35 AM, with Licensed Practical Nurse (LPN) #3 revealed that Resident #30 was independent with eating but acknowledged that after observing him, she did see that the resident needed assistance with meal and handling cups. She revealed the aides should ensure the resident had the help needed to eat and drink. An observation and interview with the Director of Nursing (DON) on 1/03/24 at 8:41 AM, of Resident #30 during breakfast meal confirmed that the resident needed assistance with breakfast meal and ability to drink and that they would let therapy know that maybe he needs an evaluation again. An observation and interview on 1/04/24 at 8:32 AM, with Resident #30 revealed him lying in bed. The head of the bed was elevated at 30 degrees and the resident was observed not eating and had consumed less than 25% of his breakfast meal. The resident drank all the thickened milk that was placed in a handled coffee cup and none of the provided orange juice that was in a regular drinking glass. The resident was non-verbal but was able to shake his head for "No" revealing the staff did not assist him with his breakfast meal. An interview on 1/04/24 at 8:50 AM, with Certified Nurse Aide (CNA) #2 revealed that Resident #30 was able to feed himself independently and did not require any assistance to her knowledge. An interview with the Therapy Director on	M 655	ensure resident's are able to drink from the cup provided to them at meals. Administrator of Assistant Director of Nursing will bring results of audits to monthly Quality Assurance/Performance Improvement meeting for 4 months beginning 1/25/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 655	Continued From page 22 01/04/24 at 10:46 AM, revealed that the Therapy Department screens all the residents quarterly and on admission for therapy needs. She revealed that Resident #30 had been evaluated by Speech Therapy on 8/7/23 with no recommendation for adaptive equipment. She confirmed that the resident received Speech Therapy services between the dates of 8/7/23 and 9/18/23 for the diagnosis of Dysphagia and Ataxia and was discharged due to the resident had achieved the highest practical level. Record review of the Admission Record for Resident #30 revealed the resident was admitted to the facility on 5/10/23 with medical diagnoses that included Hypotension, Gastro-Esophageal Reflux Disease without Esophagitis, and Unspecified Protein-Calorie Malnutrition. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #30 is cognitively intact.	M 655		