

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 complaint investigations for (CI) MS#25102 and CI MS#25495 at the facility on 06/19/24. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm related to the complaint CI MS#25102 for misappropriation and cited M500. Based on the facility's implementation of corrective actions taken on 05/14/24 prior to survey entrance, this deficient practice was determined to be Past Non-Compliance. The SA found no deficient practice for CI MS#25495 related to sexual abuse. The facility had a census of 75 at the time of the survey and held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		7/5/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/05/24

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident 's choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 2 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 4 This Statute is not met as evidenced by: Level II Past Non-compliance Based on record review, interviews and facility policy review the facility failed to prevent the misappropriation of narcotics for one (1) of four (4) medication carts in the facility. Medication cart B2. Based on the implementation of corrective actions the State Agency (SA) determined this to be Past Non-Compliance and the facility had achieved compliance on 5/14/24, prior to the SA entry. Findings Include: Review of the facility policy dated December 2012, titled, "Controlled Substances," revealed, "The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances." Record review revealed that on 05/12/24 at 7:20 PM during change of shift narcotic count for medication cart two on B hall with Licensed Practical Nurse (LPN) #1 and LPN #2 it was noticed that a pill looked different from the others in the medication card. The narcotic card was for Resident #1's "Hydrocodone-Acetaminophen 5-325 Milligrams (Norco); take 1 tablet by mouth every six hours as needed for pain." When LPN #1 flipped over the narcotic card it was observed that the card had tape on the back of slot #20 pill and the pill inside was different from the other pills in the narcotic card. An audit on 05/14/24 of the narcotic cards revealed Resident #3's "Hydrocodone-Acetaminophen 5-325 milligrams (Norco); take one tablet by mouth every six hours as needed for pain," had a piece of tape to close	M 500	Past Non-Compliance, No POC needed.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 5 over an area where a pill was removed, and the pill in slot #5 was different than the others. On 06/19/24 at 2:00 PM in an interview with LPN #2, confirmed that she notified the Director of Nurses (DON) right away and that an investigation began. She stated that the pill immediately caught her eye when she was doing the narcotic count because it was a different shape than the others in the blister pack. LPN #2 stated that the pill was white, but it was a different shape and it had the letters ATO etched on the pill. She stated that the next day on her shift that she noticed that Resident #3 had a narcotic card with tape on the back of it. She stated that it was the same situation that it was also a Norco tablet that had been replaced with another white pill with ATO etched on it. LPN #2 stated that she had never looked at the back of the narcotic cards before, but she does now after this incident. Interview with LPN #1 on 6/19/24 at 2:35 PM, confirmed that she had never seen this before and that since that day that they have never seen this happen again, but that they all had to write statements and take drug screenings during the investigation. On 06/19/24 at 4:00 PM, the DON was not in the facility during the (State Agency) SA investigation but the Administrator was interviewed and confirmed that throughout the investigation that all the nurses who had keys to all the medication carts and medications rooms were put through a drug screening and that all passed the screening. Throughout the audit and investigation, it was discovered that Resident #1 and Resident #3 were the two narcotic cards that the Norco had been removed and replaced with Atorvastatin	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 6 pill. The Administrator confirmed that each blister pack medication card had the one single area that had been punched, the Norco removed and then replaced with Atorvastatin and a piece of clear tape was applied to the back side of the narcotic card where the Norco had been removed. The Administrator confirmed that in-services were completed, medication cart audits conducted and interviews with all cognitive residents in the facility were completed and no one had an issue with not receiving pain medications. Resident #1 was admitted to the facility on 11/11/08 with diagnosis that included Crushing injury of the skull and Convulsions. The most recent Brief Interview for Mental Status (BIMS) score conducted on 06/18/24 revealed a score of 09, indicating moderate cognitive impairment. Resident #3 was admitted to the facility on 05/24/23 with diagnoses that included Dementia and Anxiety Disorder. The most recent Brief Interview for Mental Status (BIMS) score conducted on 04/01/24 revealed a score of 09, indicating moderate cognitive impairment. The SA validated on 6/19/24 through record review and staff interviews that the facility conducted an investigation that began on 05/12/24 which included medication cart audits of four medication carts on 05/12/24 and held a Quality Assurance meeting on 05/12/24; in-services on 05/13/24 with all Registered Nurses and LPNs on proper handling/use of controlled substances and narcotic counts; and conducted interviews with all cognitive residents on 05/14/24 related to narcotic medications. The Administrator stated that narcotic counts were monitored weekly for one month by the Director	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/19/2024
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 500	Continued From page 7 of Nurses with no further misappropriation noted. After review of the investigation, record reviews and interviews the SA determined that the facility was in compliance with requirements and had achieved compliance on 05/14/24.	M 500			