STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255229	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCARE CENTER	**1315 HIGHWAY 4 EAST , HOLLY SPRINGS, Mississippi, 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) COMPLETION DATE
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, and record review, the facility failed to provide adequate supervision to prevent accidents for one (1) of three (3) residents reviewed for accidents (Resident #1), when the facility did not increase monitoring despite repeated episodes of the resident entering other residents' rooms and consuming food while on NPO (nothing by mouth) status, resulting in multiple transfers to the emergency department for possible aspiration. Findings include: Review of a reported complaint related to Resident #1 revealed the resident has a Percutaneous Endoscopic Gastrostomy (PEG) tube and the facility is not monitoring him closely enough and he is getting food from various places throughout the facility. Review of a statement provided by the facility administration revealed the facility did not have any policies or procedures related to accidents, monitoring or supervision. Record review of the Admission Record revealed Resident #1 was admitted on 7/2/24 with diagnoses of personal history of traumatic brain injury and gastrostomy status.	F0689		

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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F0689 SS = G	Continued from page 1 Record review of the Brief Interview for Mental Status (BIMS) dated 10/9/25 revealed a score of 6, indicating Resident #1 was severely cognitively impaired. Record review of a Nutritional Evaluation dated 10/7/25 revealed the assessment: Resident is NPO, swallowing issues noted. “Nursing noted this a.m. (morning) that resident is still going into other residents’ rooms to take food from their trays.” Record review of the October Medication Record for Resident #1 revealed the resident was identified as High Risk for wandering/elopement, with visual monitoring every shift ordered 4/28/25. Record review of a Nurses Note for Resident #1 dated 7/3/25 at 11:36 AM revealed the Nurse Practitioner was aware of the resident eating applesauce. On 7/3/25 at 20:26 (8:20 PM), the resident appeared to be aspirating due to drinking another resident’s lemonade, coughing profusely. The resident was sent to the Emergency Department (ED) for further evaluation. Record review of the ED treatment note for Resident #1 dated 7/3/25 revealed the resident was sent from the facility for possible aspiration. The patient was noted to be in no distress during triage. Record review of a Nurses Note for Resident #1 dated 7/20/25 at 23:34 (11:34 PM) revealed the resident was observed drinking a box of liquid supplement and was educated on NPO status. Record review of a Nurses Note for Resident #1 dated 7/23/25 at 13:31 (1:31 PM) revealed staff notified the nurse that Resident #1 was in another resident’s room eating their lunch tray. The resident was spitting up chunks of food with increased salivation present. The resident was unable to take full deep breaths. Lung sounds were diminished. Orders were received to send the resident to the ED for possible aspiration. Record review of the ED treatment note for Resident #1 dated 7/23/25 revealed the reason for visit was choking. Diagnosis: Aspiration into airway. The chest x-ray showed no acute abnormality. Record review of a Nurses Note for Resident #1 dated 9/8/25 at 00:05 (12:05 AM) revealed the resident was noted in another resident’s room eating chocolate candies. On 9/8/25 at 14:56 (2:56 PM), the responsible party requested the resident be sent out for possible aspiration.	F0689		

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F0689 SS = G	Continued from page 2 Record review of the ED treatment note for Resident #1 dated 9/8/25 revealed the resident was sent from the facility. The reason for visit was documented as "eating disorder." Record review of a Nurses Note for Resident #1 dated 9/23/25 at 15:50 (3:50 PM) revealed the resident was observed sitting in his wheelchair with a snack cake in his mouth. The resident is NPO. Record review of a Nurses Note for Resident #1 dated 10/6/25 at 16:13 (4:13 PM) revealed the resident was noted in another resident's room coughing with food all around his mouth and in his chair. On 10/6/25 at 18:42 (6:42 PM), a nurse assessed crackles upon inhalation and exhalation. The nurse asked the resident if he was having trouble breathing or chest pain, and the resident nodded yes. A second nurse entered the room and stated it sounded like crackles. Orders were received to send the resident to the ED. Record review of the ED treatment note for Resident #1 dated 10/6/25 revealed the Reason for Visit was aspiration. Diagnoses included aspiration into airway and rhonchi in both lung bases. Medication changes included beginning Albuterol Hydrofluoroalkane inhaler and amoxicillin-clavulanate. Record review of the Order Summary Report for Resident #1 revealed an order for amoxicillin-clavulanate oral suspension, 7.3 milliliters (mL) via (by) PEG-tube two times daily for upper respiratory infection (URI), and Albuterol-Budesonide inhalation aerosol 90-80 MCG/ACT (micrograms per actuation), two puffs orally every four hours as needed for shortness of breath/wheezing. A continued review of the resident's record with the Minimum Data Set (MDS) Nurse on 11/24/25 at 11:20 AM revealed she could find no increase in monitoring for Resident #1 related to his continuous episodes of going into other residents' rooms and taking food. An interview with the Director of Nursing on 11/24/25 at 11:55 AM revealed Resident #1 was NPO and had a PEG tube for nutrition. She stated he had been to the hospital multiple times related to getting food "from wherever." She stated it was difficult to alter this behavior because the resident was mobile in his wheelchair and, "if he smelled food, he was going after it." She stated he was on every-shift visual monitoring for wandering behaviors but confirmed the facility had not increased monitoring despite the increase in episodes of taking food and requiring ED transfers for signs of aspiration. She stated, "We took the snacks	F0689		

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F0689 SS = G	Continued from page 3 from the desk, but if he wants it, he is going to find it." She stated the facility had been attempting placement in another facility due to his need for increased monitoring and care, but no one would accept him. She confirmed she asked administration about placing the resident on one-on-one supervision, but this never occurred. She confirmed the resident remained at risk for taking others' food and for aspiration. An interview with the Social Worker (SW) on 11/24/25 at 12:45 PM revealed she had sent numerous referrals to other facilities due to Resident #1's need for extra monitoring and care, but no facility would accept him. She confirmed that with the resident's continued attempts to obtain food, the facility should have increased his monitoring until other solutions could be found. An interview with Certified Nurse Assistant (CNA) #1 on 11/24/25 at 12:10 PM revealed she cared for Resident #1 when he lived at the facility. She stated she was not aware of any increased monitoring of the resident. She stated they tried to keep a good eye on him, but he could propel himself and "we all have other duties as well." An interview with Licensed Practical Nurse (LPN) #1 on 11/24/25 at 12:15 PM revealed she cared for Resident #1 when he was a resident. She stated the resident continuously tried to go into other residents' rooms. She confirmed she attempted to redirect him but stated this often did not work. She stated, to her knowledge, the facility never increased his monitoring to prevent him from going into other residents' rooms seeking food. An interview with the Assistant Director of Nursing on 11/24/25 at 1:00 PM revealed she was aware of Resident #1's behavior of going into other residents' rooms and obtaining food. She stated placing the resident on one-on-one supervision had been discussed, but it was not in the budget, and with other staffing concerns, "no one wanted to come in and do it." Record review revealed that the family discharged the resident from the facility on 11/06/25 prior to the State Agency entrance.	F0689		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F0684		

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F0684 SS = E	Continued from page 4 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to ensure that residents received necessary services to meet their medical needs when they allowed scheduled medical and dental appointments to be missed for (3) three of twenty-two residents with scheduled appointments. (Resident #2, #3, and #4) Findings include: Review of a statement provided by the facility on company letterhead revealed, “The facility has no policy or procedures on appointments.” Resident #2 An interview with Resident #2, on 11/24/25 at 10:00 AM revealed he confirmed that on 11/10/25, he missed an appointment with his "lung doctor." He stated that the staff told him there was no money on the gas card to put gas in the transport van. He stated his appointment was a follow-up and he is doing good but does not like missing his appointments, because when they rescheduled, he cannot be seen now until January. Record review of the calendar of scheduled appointment transfers from 10/27/25–11/10/25 provided by the facility revealed that on 11/10/25, Resident #2’s pulmonary appointment was canceled related to “van card issue” and rescheduled for 1/13/26. Record review of the Admission Record revealed Resident #2 was admitted on 4/15/25 with a diagnosis of chronic obstructive pulmonary disease. Record review of the Brief Interview for Mental Status (BIMS) dated 10/24/25 revealed a score of 15, indicating Resident #2 was cognitively intact. Resident #3 An interview with Resident #3 on 11/24/25 at 10:15 AM revealed he missed his dental appointment at the end of	F0684		

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F0684 SS = E	Continued from page 5 October. He confirmed it was because the van was out of gas and he would like to know when he is supposed to go, because he doesn't know if it was rescheduled. He denied having any pain or mouth distress. Record review of the calendar of scheduled appointment transfers from 10/27/25–11/10/25 revealed that on 10/28/25, Resident #3's dental appointment was canceled related to "gas card," and no reschedule date was provided. Record review of the Admission Record revealed Resident #3 was admitted on 1/4/23 with a diagnosis of major depressive disorder. Record review of the Brief Interview for Mental Status (BIMS) dated 9/10/25 revealed a score of 15, indicating Resident #3 was cognitively intact. Resident #4 An interview with Resident #4 on 11/24/25 at 10:25 AM revealed he missed his cardiology appointment at the beginning of November and was told it was because they had no money to fill the transport van. Record review of the calendar of scheduled appointment transfers from 10/27/25–11/10/25 revealed that on 11/7/25, Resident #4's cardiology appointment (listed under "Proper Name") was canceled related to "gas card," and no reschedule date was provided. Record review of the Admission Record revealed Resident #4 was admitted on 10/15/25 with a diagnosis of congestive diastolic heart disease. Record review of the Brief Interview for Mental Status (BIMS) dated 10/20/25 revealed a score of 13, indicating Resident #4 was cognitively intact. A phone interview with the van transport driver on 11/24/25 at 10:30 AM revealed she confirmed there were at least (3) three residents who missed their scheduled appointments between 10/27/25–11/10/25 due to not having funds on the company gas card. She stated there would have been a lot more, but the Director of Nursing (DON) and the Business Office Manager (BOM) used their personal credit cards to put gas in the transport van which allowed the residents to be able to make it to their appointments. She stated she did not know the reason for the credit card not having funds and was informed that the Administrator and corporate office were aware.	F0684		

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F0684 SS = E	Continued from page 6 An interview with the DON on 11/24/25 at 10:40 AM revealed she confirmed that between the end of October and the first week of November, Resident #2, #3, and #4 missed their scheduled appointments related to no gas in the van and no funds on the company card to put gas in the van for transport. She confirmed there would have been more, but she personally filled the van once and so did the BOM so the residents could be transported to their appointments. She stated the Administrator and corporate office were aware of the issue and it was discussed daily in stand-up. An interview with the Administrator on 11/24/25 at 10:45 AM revealed he confirmed there had been an issue with the company gas card but stated it was corrected now. He denied that the van was ever out of gas, stating he filled it up himself. He then stated he did not approve any appointments to be rescheduled due to van transport card issues. An interview with the BOM on 11/24/25 at 11:00 AM revealed she confirmed that a few residents missed their scheduled appointments related to there being no funds on the company gas card. She stated that she immediately made the corporate office and the Administrator aware of the issues with the credit card. She stated this went on for about two weeks and that she put gas in the van once because she did not want residents to miss their appointments.	F0684		
F0000	INITIAL COMMENTS The State Agency (SA) conducted three (3) onsite complaint investigations (CI) (MS# 2614879, MS CI# 2635563, and MS CI# 2671788) at the facility on 11/24/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid for MS CI# 2614879, MS CI# 2635563 and cited F 689 related to Accidents. The SA also found the facility was not in compliance with CI MS #2671788 and cited F 684 related to Quality of Care. The census at the time of the survey was 86 and the facility is licensed for 120 beds.	F0000		