STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0500	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; 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	M0500		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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M0500	Continued from page 1 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 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;	M0500		

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M0500	Continued from page 2 11. is not required to perform services for the facility that are not included for therapeutic 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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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	M0500		

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M0500	Continued from page 3 dental appointments to be missed for (3) three of 22 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 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.	M0500		

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M0500	Continued from page 4 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. 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	M0500		

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M0500	Continued from page 5 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.	M0500		
M0640	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 LICENSURE 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.	M0640		

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M0640	Continued from page 6 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.	M0640		

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M0640	Continued from page 7 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	M0640		

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M0640	Continued from page 8 episodes of taking food and requiring ED transfers for signs of aspiration. She stated, “We took the snacks 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.	M0640		
M0000	Initial Comments	M0000		

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M0000	Continued from page 9 The State Agency (SA) conducted three (3) onsite complaint investigations (CI) MS CI# 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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm for MS CI# 2614879 and MS CI# 2635563 and cited M 640. The SA also found the facility was not in compliance with CI MS #2671788 and M 500. The census at the time of the survey was 86 and the facility is licensed for 120 beds.	M0000		