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 05/14/2026

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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI), MS #2970205 at the facility from 5/11/26 through 5/14/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F677 for CI MS #2970205 for Activities of Daily Living (ADL). The SA also cited F868, F565, F656, F550, F578, F584, F628, F688, F698, and F880 during the annual recertification survey. The census at the time of the survey was 95 and the facility is licensed for 120 beds.	F0000		
F0868 SS = F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F0868		

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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F0868 SS = F	Continued from page 1 (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to have the required staff present and in attendance for each quarterly Quality Assurance and Performance Improvement (QAPI) meetings for four (4) of 4 quarterly meetings dated 09/30/25, 12/29/25, 03/31/26 and 05/01/26. Findings include: Review of facility document titled “QAPI Program” undated revealed, “…Leadership of the QAPI committee will include the Medical Director and or Nurse Practitioner (NP), Administrator, and Director of Nurses…QAPI meetings will be held monthly. The following individuals serve on the committee: Administrator, or a designee who is in a leadership role; Director of Nursing services; Medical Director; Infection Preventionist; and Representatives of the following departments, as requested by the administrator: Pharmacy; Social Services; Activity Services; Environmental Services; Human Resources; and Medical Records.” Review of facility documents titled “Stand Up Sign-in Sheet/QA Meeting” dated 9/30/2025, 12/29/2025, 3/31/2026, and 5/1/2026, failed to evidence participation of the facility Medical Director in the QAPI meetings reviewed. During an interview on 5/14/2026 at 9:30 AM, the Administrator stated the facility discussed concerns during QAPI meetings but was unable to provide evidence of additional ongoing performance improvement activities, sustained monitoring tools, or systemic corrective actions related to the identified recurring concerns. Additionally, the	F0868		

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F0868 SS = F	Continued from page 2 Administrator confirmed the Medical Director did not attend the QAPI meetings. He stated, “I usually just call and fill her in about the meetings,” and confirmed that the Medical Director was not in attendance at any of the QAPI meetings.	F0868		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to	F0565		

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F0565 SS = E	Continued from page 3 resolve resident grievances related to food service concerns identified during Resident Council meetings for five (5) of thirteen residents. (Resident #7, Resident #11, Resident #36, Resident #62, and Resident #74) Findings Include: Review of the facility policy titled “Filing Grievances/Complaints” with a revision date of 6/2024 revealed “...3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing (if requested), including a rationale for the response...” A record review of the “Resident Council Minutes” dated 12/16/25, under “New Business,” revealed residents voiced concerns stating, “The food is inedible and not worth eating,” and “The food is awful, it’s the same every time and never a different variety.” The minutes documented the Dietary Manager (DM) was present during the meeting. A record review of the “Resident Council Minutes” dated 1/20/26, under “Old Business,” revealed continued complaints that “The food is awful and always the same.” A record review of the “Resident Council Minutes” dated 2/17/26, under “New Business,” revealed residents voiced concerns including not receiving the foods listed on their meal tickets, tea glasses not being full or containing ice, repeated desserts such as fig newtons and graham crackers, green beans being served three days in a row, and food being served cold. The minutes documented the DM was present during the meeting. A record review of the “Resident Council Minutes” dated 3/16/26, under “New Business,” revealed residents complained of inadequate food portions, cold food, repetitive menu items such as rice and green beans being served multiple days in a row, lack of fresh fruit or sliced apples, receiving water instead of tea or lemonade, insufficient meat portions for sandwiches, not receiving the advertised “meal of the month,” and soup or oatmeal being served in dessert cups. A record review of the “Resident Council Minutes” dated 4/21/26, under “New Business,” revealed complaints that the food was “too salty.” Under “Old Business,” residents continued to voice concerns that the food was not hot, the food was	F0565		

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F0565 SS = E	Continued from page 4 "awful," and fresh fruit was not being provided. The minutes documented the DM was present during the meeting. During an interview on 5/12/26 at 1:51 PM, the Activity Director (AD) confirmed that cold food and food issues had been an ongoing concern discussed during Resident Council meetings "for a while." The AD stated the DM routinely attended the meetings and residents consistently voiced their concerns to him. The AD further stated she was unaware of any actions taken by the DM to resolve the issues. During the Resident Council meeting conducted on 5/12/26 at 2:00 PM, residents who were present continued to voice concerns regarding unresolved food service issues that had reportedly been discussed repeatedly during prior Resident Council meetings without a follow up or a resolution to their prior grievances. Resident #7 revealed he had repeatedly requested coffee prior to leaving for dialysis, but coffee service occurred after he had already left the facility. He further revealed the oatmeal was usually cold "and it can't even melt butter." Resident #7 stated he had discussed the concerns with both the DM and the Administrator (ADM), but "Nothing ever gets done." Resident #11 revealed "The food is cold regardless of what you get," and stated, "We discuss these food issues all the time, and it falls on deaf ears." Resident #36 revealed that "The majority of our Resident Council meetings we are discussing cold food and how bad the food is." She stated the DM attends the meetings, listens to the concerns, but "Nothing is ever done." Resident #36 further revealed residents discuss the "Meal of the month" during each meeting; however, they have never received those meals that they request. Resident #62 revealed, "We talk about food issues in each meeting that we have. We just haven't seen any change." Resident #74 revealed, "It doesn't matter if we mention how cold or bad the food is; nothing is ever done." He stated the DM attends the meetings and listens to the complaints, and that the Administrator and staff were aware of the residents' concerns. During an interview on 5/12/26 at 3:50 PM, the Administrator (ADM) confirmed awareness of ongoing food-related complaints voiced during	F0565		

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F0565 SS = E	Continued from page 5 Resident Council meetings. The ADM revealed the DM had attended several meetings and had been made aware of the concerns. The ADM stated, “I know there have been ongoing concerns about the food, and we are trying to change things up.” The ADM confirmed there was no written follow-up documentation regarding the residents’ grievances and acknowledged the facility had failed to ensure the residents’ concerns were properly addressed and resolved. During an interview on 5/13/26 at 11:40 AM, the DM confirmed awareness of the concerns voiced during Resident Council meetings and stated he had discussed with residents that he was working to resolve the issues. The DM confirmed there was no documented follow-up and acknowledged the concerns had apparently not been resolved at that time. Record review of the “Admission Record” revealed the facility admitted Resident #7 on 8/13/2025 with medical diagnoses that included Muscle weakness and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/9/2026 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #7 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #11 on 4/04/2025 with medical diagnoses that included Protein-Calorie Malnutrition and Anemia. Record review of the MDS with an ARD of 4/2/26 revealed under section C, a BIMS summary score of 15, indicating Resident #11 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #36 on 12/19/2025 with medical diagnoses that included Type 2 Diabetes Mellitus and Major Depressive Disorder. Record review of the MDS with an ARD of 3/26/26 revealed under section C, a BIMS summary score of 15, indicating Resident #36 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #62 on 8/01/2024 with medical diagnoses that included Schizophrenia and Anemia. Record review of the MDS with an ARD of 4/17/26 revealed under section C, a BIMS summary score of	F0565		

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F0565 SS = E	Continued from page 6 14, indicating Resident #62 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #74 on 11/25/2021 with medical diagnoses that included Chronic Obstructive Pulmonary Disease and Anemia. Record review of the MDS with an ARD of 4/8/26 revealed under section C, a BIMS summary score of 14, indicating Resident #74 was cognitively intact.	F0565		
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F0656		

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F0656 SS = E	Continued from page 7 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to implement care plan interventions as written for three (3) of 19 sampled residents. (Resident #2, Resident #27, and Resident #39) The scope and severity for this deficiency were cited at an "E" due to previous citations of F656 on the last two annual recertification surveys completed on 1/4/24 and 6/19/25 representing a pattern of deficiency. Findings include: Review of the facility policy titled “Care Plans, Comprehensive Person-Centered,” reviewed 6/2/25, revealed, “A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident..." Resident #2 Review of "Care Plan Report" revealed under "Focus: The resident has an ADL (activity of daily living) deficit r/t (related to CVA (cerebrovascular accident)…Interventions...Staff to ask resident on shower days if they would like to be shaved and shave as needed (prn) resident or Responsible Party (RP) request". Observations on 5/11/2026 at 11:05 AM, and again on 5/12/2026 at 9:00 AM, of Resident #2 revealed his facial hair was approximately one (1) inch in length. On 5/12/2026 at 1:00 PM during an observation and interview Licensed Practical Nurse (LPN) #1 confirmed that Resident #2 has long facial hair. She stated his shower days are Monday, Wednesday, Friday, and that a Certified Nursing Assistant (CNA) comes on Wednesdays, Thursdays, and Fridays to	F0656		

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F0656 SS = E	Continued from page 8 shave residents. On 5/13/2026 at 9:40 AM, Minimum Data Set (MDS) Coordinator confirmed the care plan had been developed; however, facility staff failed to implement the interventions as written. She stated the purpose of the care plan was to guide staff in providing the care needed for Resident #2. Record review of the Admission Record indicated Resident #2 was admitted to the facility on 8/18/2022 with medical diagnoses that included Cerebral Infarction. Record review of the MDS, with an Assessment Reference Date (ARD) of 4/09/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) was 9, indicating moderate cognitive impairment. Resident #27 Record review of Resident #27's "Self-Care Deficit" Care Plan revealed, "…CNA (Certified Nursing Assistant) to complete fingernail care for resident daily and PRN. CNA to trim/file fingernails PRN…Donn (apply) carrots to bilateral hands daily after lunch and doff (remove) at HS (bedtime) one time a day. Donn bilateral elbow rolls to resident daily after lunch and doff at HS one time a day…" On 5/11/2026 at 11:05 AM, during an observation Resident #27's fingernails were observed to be approximately one (1) inch in length with jagged edges. The resident was also observed with contractures to bilateral hands without the ordered interventions in place. Observations of Resident #27 on 5/12/2026 at 9:54 AM and again at 12:44 PM, revealed no carrots, rolled cloths, or gauze in either hand for contracture prevention and the resident's fingernails were jagged and long. During an interview on 5/12/2026 at 2:57 PM, the Director of Nursing (DON) confirmed several of Resident #27's fingernails were very long. She stated long, jagged fingernails could cause injury to the resident and should be kept clean and trimmed. She further confirmed Resident #27 did not have ordered interventions in place for his hands or elbows to prevent contractures. On 5/13/2026 at 9:38 AM, Registered Nurse (RN) MDS Coordinator confirmed the care plan had been	F0656		

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F0656 SS = E	Continued from page 9 developed; however, facility staff failed to implement the interventions as written. She stated the purpose of the care plan was to guide staff in providing care for Resident #27. Record review of the Admission Record indicated Resident #27 was admitted to the facility on 6/20/2025 with medical diagnoses that included unspecified severe protein-calorie malnutrition and primary progressive multiple sclerosis. Record review of the MDS, with an ARD of 2/14/2026, revealed under Section C that a BIMS was not conducted because Resident #27 was rarely or never understood. Resident #39 Record review of Resident #39's Activities of Daily Living (ADL) self-care performance deficit care plan revealed, "…Donn resting hand splint to left hand after breakfast daily and doff at dinner or as tolerated; check skin prior to donning left hand splint and after doffing left hand splint…oral hygiene: dependent…Personal hygiene: dependent…" During an observation on 5/11/2026 at 10:32 AM, Resident #39's fingernails were observed to be approximately one (1) inch in length with jagged edges. Additionally, the resident's upper teeth appeared blackened and deteriorated with visible buildup along the gum line. Significant discoloration and poor oral hygiene were observed. Resident #39 was also observed without the ordered splint in place on his left hand. On 5/12/2026 at 9:51 AM and again at 2:16 PM, observations of Resident #39 revealed no brace or splint in place on the resident's left hand. During the 2:16 PM observation, when asked about the brace, the resident stated he did not know where it was but stated it "helps to hold his hand open." On 5/12/2026 at 2:37 PM during an interview the Director of Nursing (DON) confirmed Resident #39 was in need of oral care and that his fingernails should be kept trimmed. She stated nail care and oral care should be provided daily and as needed. She further confirmed braces and splints should be applied as ordered to assist in preventing contractures and stated her expectation was for physician orders to be followed as written. During an interview on 5/13/2026 at 9:38 AM, the Minimum Data Set (MDS) Coordinator confirmed the	F0656		

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F0656 SS = E	Continued from page 10 care plan had been developed; however, facility staff failed to implement the interventions as written. She stated the purpose of the care plan was to guide staff in providing care for Resident #39. Record review of the Admission Record indicated Resident #39 was admitted to the facility on 6/26/2024 with medical diagnoses that included post-traumatic seizures, hemiplegia affecting the left nondominant side, and metabolic encephalopathy. Record review of the MDS, with an ARD of 3/23/2026, revealed under Section C a BIMS summary score of 9, indicating Resident #39 was moderately cognitively impaired.	F0656		
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide facial hair grooming, fingernail care, and oral hygiene for three (3) of nineteen (19) samples residents reviewed for activities of daily living (ADL) care. Residents #2, Resident #27, and Resident #39. The scope and severity for this deficiency was cited at an "E" due to previous citations of F677 on the last two annual recertification surveys completed on 1/4/24 and 6/19/25 representing a pattern of deficiency. Findings include: Review of the facility policy titled “Activities of Daily Living (ADL),” with a revision date of March 2018, revealed, “Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living..." Resident #2 On 5/11/2026 at 11:05 AM, and again on 5/12/2026 at 9:00 AM, observations of Resident #2 revealed facial hair that was approximately one (1) inch in length.	F0677		

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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
F0677 SS = E	Continued from page 11 During an observation and interview on 5/12/2026 at 1:00 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #2 had long facial hair. She stated his shower days are on Mondays, Wednesdays, Fridays, and that a Certified Nursing Assistant (CNA) comes on Wednesdays, Thursdays, and Fridays to shave residents. During an interview on 5/14/2026 at 8:45 AM, the Administrator stated residents should be offered a shave on shower days. Record review of the Admission Record indicated Resident #2 was admitted to the facility on 8/18/2022 with medical diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/09/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) was 9, indicating moderate cognitive impairment. Resident #27 During an observation on 5/11/2026 at 11:05 AM, Resident #27's fingernails were observed to be approximately one (1) inch in length with jagged edges. During an interview on 5/12/2026 at 2:43 PM, CNA #2 confirmed several of Resident #27's fingernails were very long. She stated she was unsure whether she could trim the resident's fingernails because the resident "might be diabetic" and stated, "I would have to ask the nurse." During an interview on 5/12/2026 at 2:57 PM, the Director of Nursing (DON) confirmed several of Resident #27's fingernails were very long. She stated long, jagged fingernails could cause injury to Resident #27 and should be kept clean and trimmed. Record review of the Admission Record indicated Resident #27 was admitted to the facility on 6/20/2025 with medical diagnoses that included unspecified severe protein-calorie malnutrition and primary progressive multiple sclerosis. Record review of the MDS, with an ARD of 2/14/2026, revealed under Section C that a BIMS was not conducted because Resident #27 was rarely or never understood. Resident #39	F0677		

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F0677 SS = E	Continued from page 12 During an observation on 5/11/2026 at 10:32 AM, Resident #39's fingernails were observed to be approximately one (1) inch in length with jagged edges. Additionally, the resident's upper teeth appeared blackened and deteriorated, with visible buildup along the gum line. Significant discoloration and poor oral hygiene were observed. During an interview on 5/12/2026 at 2:29 PM, the DON confirmed Resident #39 needed oral care and that his fingernails should be kept trimmed. She stated nail care and oral care should be provided daily and as needed. Record review of the Admission Record indicated Resident #39 was admitted to the facility on 6/26/2024 with medical diagnoses that included post-traumatic seizures, hemiplegia affecting the left nondominant side, and metabolic encephalopathy. Record review of the MDS, with an ARD of 3/23/2026, revealed under Section C a BIMS summary score of 9, indicating Resident #39 was moderately cognitively impaired.	F0677		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550		

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F0550 SS = D	Continued from page 13 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a dignified existence by failing to apply a privacy bag to a urinary catheter drainage bag (Resident #82) and failing to provide dignified toileting assistance to a resident (Resident #22) for two (2) of 19 sampled residents. Residents #22 and Resident #82. Findings Include: Record review of facility policy titled “Nursing Facility Resident Rights” dated 3/6/26 revealed, “...Facilities are required to protect and promote these rights for every resident. Dignity, Respect, and Freedom from Abuse: To be treated with dignity, courtesy, and respect...Quality of Care and Participation in Care: To receive care necessary to achieve the highest practicable physical, mental, and psychosocial well-being...” Resident #22 On 5/11/26 at 11:22 AM, observation and interview with Resident #22 revealed she was sitting in her wheelchair near the doorway of her room with frowning facial expressions and scrunched eyebrows. Resident #22 stated she needed to use the bathroom to have a bowel movement, but staff told her they could not put her on the toilet, and she would have to lie in bed, use the bathroom on herself, and then be changed. Resident #22 pointed toward her bed and stated she did not want to lie in	F0550		

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F0550 SS = D	Continued from page 14 bed and use the bathroom on herself. An interview with Certified Nursing Assistant (CNA) #1 on 5/11/26 at 11:25 AM confirmed she told Resident #22 she would have to lie in bed to use the bathroom. During an interview on 5/12/26 at 5:22 PM, the Director of Nursing (DON) revealed Resident #22 required a total lift and the lift would not fit into the bathroom. The DON stated the facility did not have any bedside commodes available; however, the resident should have been offered a bedpan. The DON acknowledged being told to use the bathroom on herself was a dignity concern. Record review of the “Admission Record” revealed the facility admitted Resident #22 on 4/13/26 with medical diagnoses that included Acute Kidney Failure, Chronic Kidney Disease, Anxiety Disorder, and Depression. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, indicating Resident #22 was moderately cognitively impaired. Resident #82 During an observation on 5/11/26 at 10:20 AM, Resident #82’s catheter drainage bag was observed hanging on the lower bed frame, approximately one-third full of amber-colored urine, without a privacy cover in place. Record review of the “Order Summary Report” revealed an order dated 7/28/23 for “Privacy bag or covering over urine collection bag for dignity.” During an interview on 5/12/26 at 12:50 PM, Licensed Practical Nurse (LPN) #3 stated the urinary drainage bag should have a cover in place to provide privacy for the resident. Record review of the “Admission Record” revealed	F0550		

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F0550 SS = D	Continued from page 15 the facility admitted Resident #82 on 7/25/23 with medical diagnoses that included Chronic Kidney Disease, Stage 3, Benign Prostatic Hyperplasia, and Personal History of Malignant Neoplasm of Prostate. Record review of the MDS with an ARD of 4/21/26 revealed under Section C, a BIMS summary score of 12, indicating Resident #82 was moderately cognitively impaired.	F0550		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up	F0578		

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F0578 SS = D	Continued from page 16 procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on resident/resident representative (RR) and staff interviews, record review and facility policy review the facility failed to honor a resident's Advance Directive for end-of life decisions for one (1) of 28 residents advance directives reviewed. Resident #25 Findings Include: Review of the facility policy titled “Advance Directives”, with a revision date of Aug 2023, revealed, “Advance directives will be respected in accordance with state law and facility policy…15. In accordance with current regulatory definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to:..f. Do Not Resuscitate- indicates that in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used...” Record review of the “Advance Health Care Directive” for Resident #25, revealed under “End -of-life decisions…Choice Not to Prolong Life” signed by the resident and notarized with a date of 2/20/24. Record review of the “Order Summary Report” revealed an order for CPR with a date of 05/02/2025. During an interview on 5/13/2026 at 8:27 AM, Licensed Practical Nurse (LPN) #3 confirmed Resident #25’s physician order reflected full code status. During a phone interview on 5/13/2026 at 9:13 AM, Resident #25’s Resident Representative (RR) stated, “My sister has always said she did not want to be resuscitated." The RR stated the facility contacted him some time ago, "but I truly didn’t understand what they were asking me." He stated, “A girl asked if they should do anything for her if she quits breathing, and I responded, 'Well, I guess you should.” The RR revealed he was unaware this would change his sister's previously established end-of-life wishes, which were documented when	F0578		

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F0578 SS = D	Continued from page 17 she was in a better mindset, and they should keep them as she wanted. In an interview on 5/13/2026 at 9:22 AM, Resident #25 confirmed her end-of-life wishes were that she had no resuscitation if anything happened to her. She stated, “I have always said that because I have heart disease and a pacemaker," and further confirmed that she had completed paperwork documenting those wishes. In an interview on 5/13/2026 at 9:48 AM, the Director of Nurses (DON) confirmed Resident #25 had an "Advance Health Care Directive" signed on 2/20/24, indicating under “End-of-Life Decisions” a “Choice Not to Prolong Life.” The DON confirmed the residents’ previously documented end-of-life decisions should have remained consistent with the advance directive despite the change in the RR. During an interview on 5/13/2026 at 11:11 AM, the Director of Business Development revealed that she is responsible for discussing end-of-life decisions with residents and/or the RRs. She revealed she contacted Resident #25’s RR the previous year after he assumed responsibility as the resident’s RR because the facility needed to update paperwork, including the code status. Record review of the "Admission Record" revealed Resident #25 was initially admitted to the facility on 7/19/2024 with diagnoses that include Unspecified Dementia, Chronic Kidney Disease, and Presence of Cardiac Pacemaker. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/7/26 revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated Resident #25 has severe cognitive impairment.	F0578		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike	F0584		

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F0584 SS = D	Continued from page 18 environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean and sanitary environment by allowing a resident bathroom toilet to remain soiled for one (1) of 32 rooms on the 200 hall. Room 205 Findings Include: Review of the facility policy titled “7-Step Daily Washroom Cleaning” revealed under, “Purpose: To teach Environmental Services employees the proper method to sanitize a washroom or bathroom...” Additionally, the policy revealed under, “7-Step Daily Washroom Cleaning Procedure:… 5. Clean and Sanitize Commode - …Use Johnny mop or toilet brush to disinfect the inside of the bowl...”	F0584		

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F0584 SS = D	Continued from page 19 An observation of room 205's bathroom toilet on 5/11/26 at 2:15 PM revealed dark yellow stagnant urine present inside the toilet bowl and black discoloration adhered along the inner rim/water line of the toilet. The black substance appeared as multiple small circular black spots with a mold-like appearance. An observation and interview on 5/11/26 at 2:21 PM with Licensed Practical Nurse (LPN) #4 confirmed there was stagnant urine in the toilet bowl and a black substance along the water line. She stated, "It looks like mold." She confirmed the bathroom environment was unclean and unsanitary. An observation and interview with the Training Center Accounts Manager (TCAM) on 5/11/26 at 2:26 PM confirmed the toilet was unclean and that the inside of the toilet "looks to have mold." He revealed housekeeping staff were responsible for cleaning the residents' bathrooms, including the toilets, every day, confirming the toilet had not been properly cleaned.	F0584		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy	F0628		

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F0628 SS = D	Continued from page 20 of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F0628		

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F0628 SS = D	Continued from page 21 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written	F0628		

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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

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F0628 SS = D	Continued from page 22 notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent	F0628		

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F0628 SS = D	Continued from page 23 of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure the resident and/or resident representative were provided with written notification of transfer to the hospital for two (2) of 2 residents reviewed for hospitalization. Resident #3 and Resident #95 Findings Include:Review of the facility policy titled, "Transfer or Discharge Notice" with a revised date of 3/3/2026 revealed, "...5. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which is resident is being transferred or discharged." Record review of Resident #3's "Progress Note" dated 5/8/26 revealed the Resident was transported to "Proper Name of Hospital" for tube/drain replacement. Record review of Resident #95's "Progress Note" dated 3/27/26 revealed Nurse Practitioner (NP) recommended sending to Emergency Room (ER) for evaluation due to hitting head. Emergency Medical Transport (EMT) transported resident to "Proper Name of Hospital." During an interview on 5/13/2026 at 11:26 AM, the Business Office Manager (BOM) revealed when a resident is transferred to the hospital, the facility only sends the bed-hold notice and notifies the ombudsman. She further revealed the facility was unaware that a written notification explaining the reason, date of transfer, and location of transfer was required to be provided to the resident and/or resident representative. Record review of the "Admission Record" revealed the facility admitted Resident #3 on 4/18/25 with a medical diagnosis that included Disease of Biliary Tract. Record review of the "Admission Record" revealed the facility admitted Resident #95 on 3/12/26 with a medical diagnosis that included Malignant Neoplasm of unspecified part of unspecified Bronchus.	F0628		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident	F0688		

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F0688 SS = D	Continued from page 24 who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to provide necessary care and services to prevent worsening contractures and maintain range of motion (ROM) for two (2) of four (4) residents reviewed. (Residents #27 and Resident #39) Findings include: Review of facility policy titled “Contracture Management Program” revised 3/4/2026, revealed, "Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of Range of Motion…Nursing Responsibilities:…When the resident is discharged from therapy and a Restorative Nursing Program (RNP) has been written, the Director of Nursing (DON) or designee is to ensure the RNP is written correctly and then implemented timely…” Resident #27 Review of Resident #27’s “Order Summary Report,” revealed physician orders to “Donn (apply) bilateral elbow rolls to patient daily after lunch and doff (remove) at HS (bedtime)” and “Donn carrots to bilateral hands daily after lunch and doff at HS,” both with a start date of 2/21/2024. During an observation on 5/11/2026 at 2:05 PM, Resident #27 was observed with contractures to bilateral hands and elbows without ordered interventions in place.	F0688		

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F0688 SS = D	Continued from page 25 During an observation on 5/12/2026 at 2:44 PM, Resident #27 did not have carrots, rolled cloths, or gauze in either hand for contracture prevention and did not have bilateral elbow rolls or splints in place. During an observation and interview on 5/12/2026 at 2:57 PM, Licensed Practical Nurse (LPN) #2 confirmed Resident #27 did not have carrots, towels, or gauze in either hand or did not have bilateral elbow rolls in place as ordered. LPN #2 searched the resident's room and found two elbow rolls in the chest of drawers and two carrots in the bedside table drawer. During an interview on 5/12/2026 at 3:04 PM, the Director of Nursing (DON) confirmed Resident #27 did not have the ordered interventions in place for his hands or elbows to assist in preventing worsening contractures. Record review of the Admission Record indicated Resident #27 was readmitted to the facility on 6/20/2025 with medical diagnoses that included unspecified severe protein-calorie malnutrition and primary progressive multiple sclerosis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/14/2026, revealed under Section C that a Brief Interview for Mental Status (BIMS) was not conducted because Resident #27 was rarely or never understood. Resident #39 Review of Resident #39's "Order Summary Report," revealed physician orders dated 01/14/26 to "Check skin prior to donning left hand splint and after doffing left hand splint two times a day" and to "Donn resting hand splint to left hand after breakfast daily and doff at dinner or as tolerated; may remove prior to dinner if not tolerated..." During observations on 5/11/2026 at 10:32 AM and again on 5/12/2026 at 9:51 AM, Resident #39 was observed without the ordered splint in place on his left hand. During an additional observation and interview on 5/12/2026 at 2:16 PM, Resident #39 was again observed without a splint or brace on his left hand. When asked about the brace, the resident stated he did not know where it was but stated it "helps to hold his hand open." During an interview and record review on 5/12/2026 at 2:18 PM, Licensed Practical Nurse (LPN) #5	F0688		

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F0688 SS = D	Continued from page 26 stated, “I really don’t know about any brace, I don’t usually work this hall.” Review of the Medication Administration Record (MAR) revealed the splint order was listed on the MAR. LPN #5 further stated the brace was used to help prevent contractures and confirmed that they have not been on the resident. During an interview on 5/12/2026 at 2:37 PM, the Director of Nursing (DON) confirmed braces and splints should be applied as ordered to assist in preventing contractures. She stated her expectation was for physician orders to be followed as written. Record review of the Admission Record indicated Resident #39 was admitted to the facility on 6/26/2024 with medical diagnoses that included post-traumatic seizures, hemiplegia affecting the left nondominant side, and metabolic encephalopathy. Record review of the MDS, with an ARD of 3/23/2026, revealed under Section C a BIMS summary score of 9, indicating Resident #39 was moderately cognitively impaired.	F0688		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and policy review, the facility failed to clarify a clinically questionable dialysis fluid restriction order, failed to accurately transcribe and implement the physician order, and failed to monitor fluid intake for one (1) of five (5) residents reviewed for dialysis services. Resident #22 Findings Include: Review of the facility policy titled “Dialysis Management Policy” revised 3/12/26 revealed under, “Policy: The facility will ensure that residents requiring dialysis receive appropriate clinical oversight, coordination with dialysis providers, and monitoring to maintain health and safety…. The facility will coordinate care with the dialysis center and physician to ensure appropriate monitoring of	F0698		

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F0698 SS = D	Continued from page 27 the resident's clinical status, dialysis access, laboratory values, dietary needs, and complications related to dialysis therapy..." Record review of Resident #22's Medication Administration Record (MAR) revealed an order dated 4/13/26, "Resident to receive dialysis 3 (three) days a week on Tues (Tuesday), Thurs (Thursday), Sat (Saturday) at 'Proper name of dialysis center'." Record review of the "Proper name of dialysis center Physician Order Sheet" for Resident #22 revealed an order dated 4/14/26 for "3200 fluid ounces daily fluid restriction," which reflected a clinically questionable fluid restriction amount for a resident receiving dialysis. Record review of Resident #22's MAR revealed the facility transcribed and implemented the order dated 4/14/26 as, "Fluid Restriction: Resident to have 3200 cc/ml (cubic centimeters/milliliters) fluid per 24 hours. Dietary to give 1600 cc/ml per shift. Nursing to give 1600 cc/ml per shift," without obtaining clarification from the dialysis center or physician regarding the questionable order. Further review of the MAR revealed no documented monitoring or tracking of fluid intake since the resident admitted to the facility on 4/13/26. On 5/12/26 at 4:26 PM, during a telephone interview with the Registered Nurse (RN) at "Proper name of dialysis center", she revealed 3200 fluid ounces was not an accurate fluid restriction order and stated dialysis residents were typically instructed to follow approximately a 32-ounce (946 milliliters) daily fluid restriction. The RN confirmed the order should have been clarified by the facility prior to implementation. During an interview with the Director of Nursing (DON) on 5/13/26 at 10:08 AM, she confirmed the fluid restriction order received from the dialysis center was not realistic and they should have communicated with the dialysis center and clarified the order. The DON stated the nurse who received the order then converted the order from ounces to milliliters without obtaining physician or dialysis center clarification. The DON further confirmed the facility monitored dialysis residents' fluid intake through MAR documentation; however, Resident #22's fluid intake had not been monitored or documented since admission, which could result in excess fluid accumulation. Record review of the "Admission Record" revealed the facility admitted Resident #22 on 4/13/26 with	F0698		

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F0698 SS = D	Continued from page 28 diagnoses including Acute Kidney Failure, Chronic Kidney Disease, and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicated Resident #22 was moderately cognitively impaired. Further review revealed under Section O, dialysis was indicated.	F0698		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880		

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F0880 SS = D	Continued from page 29 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to implement infection prevention and control practices for one (1) of two (2) sampled residents reviewed for transmission-based precautions (TBP). The facility failed to ensure proper infection control measures related to disposable meal tray use and cleaning/disinfection of a shared shower room following use by a resident on transmission-based precautions. Resident #8 Findings Include: Review of the facility policy titled, "Infection Prevention and Control Program," with a review date of 3/03/2026 revealed, "An infection prevention and control program (IPCP) is established and maintained	F0880		

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F0880 SS = D	Continued from page 30 to provide a safe, sanitary and comfortable environment and to help prevent the development and transmissions of communicable diseases and infections..." Record review of physician orders revealed Resident #8 had an order dated 04/24/2026 for contact isolation precautions related to ESBL (Extended-Spectrum Beta-Lactamase) in wound every shift until 06/06/2026. On 5/12/2026 at 9:21 AM, observation revealed Resident #8, who was on transmission-based precautions, was served breakfast on a regular reusable tray rather than a disposable tray, the tray was picked up by an unidentified staff member and carried out with other trays. During an interview on 5/12/2026 at 3:50 PM, the Infection Preventionist (IP) stated she sent a message to dietary staff at approximately 8:00 AM regarding disposable trays for residents in isolation. She also confirmed food trays for residents on transmission-based precautions should be disposable. During an interview on 5/12/2026 at 9:30 AM with Housekeeper #1, she stated the shower room Resident #8 uses, she routinely cleans it at 6:00 AM, and again at approximately 2:00 PM daily. During an interview on 5/12/2026 at 9:42 AM, Infection Preventionist stated residents on transmission-based precautions should be showered last and the shower room should be cleaned after use. She confirmed allowing another resident to use the shower room prior to cleaning was not proper infection control practice. An observation on 5/12/2026 at 10:00 AM revealed Resident #8, who was on transmission-based precautions, was transported to the shower room and showered in the common shower area prior to other residents completing their showers for the day. Observation revealed that the shower room was not disinfected after use. An interview with the Director of Nursing at 10:45 AM on 5/12/2026 confirmed infection control practices should be used to prevent the spread of infection. Record review of the Admission Record indicated Resident #8 was admitted to the facility on 10/31/2025 with medical diagnoses that included Atherosclerotic Heart Disease.	F0880		

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F0880 SS = D	Continued from page 31 Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/10/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) score was 9, indicating moderate cognitive impairment.	F0880		