Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with one (1) complaint, MS CI # 2970205 at the facility from 5/11/26 - 5/14/26. 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. The SA identified non-compliance and cited M610 for MS CI # 2970205 for ADLs. The SA also cited M500, M625, M655, M975, and M1570. The census at the time of the survey was 95 and the facility is licensed for 120 beds.	M0000		
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	M0500		

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

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M0500	Continued from page 1 referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff 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	M0500		

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M0500	Continued from page 2 personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic 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	M0500		

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M0500	Continued from page 3 exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident/resident representative and staff interviews, record review, and facility policy review, the facility failed to ensure residents were treated with dignity and respect related to privacy and toileting assistance (Resident #22, #82) and failed to ensure residents' rights were honored by failing to address food concerns, (Resident #7, #11, #36, #62, #74) and failing to honor a resident's right to formulate end-of life decisions (Resident #25) for eight (8) of 19 sampled residents. Findings Include: Dignity 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 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	M0500		

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M0500	Continued from page 4 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 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.	M0500		

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M0500	Continued from page 5 Food Grievances 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 “awful,” and fresh fruit was not being provided. The minutes documented the DM was present during the meeting.	M0500		

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M0500	Continued from page 6 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 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	M0500		

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M0500	Continued from page 7 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 14, indicating Resident #62 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #74 on 11/25/2021 with	M0500		

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M0500	Continued from page 8 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. Advance Directives 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 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.	M0500		

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M0500	Continued from page 9 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.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	M0610		

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M0610	Continued from page 10 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 elevated due to previous citations of M610 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. 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,	M0610		

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M0610	Continued from page 11 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 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.	M0610		

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M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 for two (2) of four (4) residents reviewed for range of motion (ROM). (Residents #27 and #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. 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	M0625		

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M0625	Continued from page 13 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 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	M0625		

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M0625	Continued from page 14 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.	M0625		
M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interview, dialysis staff interview, 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 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’.”	M0655		

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M0655	Continued from page 15 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 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,	M0655		

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M0655	Continued from page 16 dialysis was indicated.	M0655		
M0975	45.33.5 Toilet Room Cleanliness Toilet Room Cleanliness. Floors, walls, ceilings, and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toilet articles, etc. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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...” 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.	M0975		

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M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 to provide a safe, sanitary and comfortable environment and to help prevent the development and transmissions of communicable diseases and infections..."	M1570		

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M1570	Continued from page 18 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. 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	M1570		

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M1570	Continued from page 19 Mental Status (BIMS) score was 9, indicating moderate cognitive impairment.	M1570		