

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2022
NAME OF PROVIDER OR SUPPLIER HOLLY SPRINGS REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey MS00017941 and MS00018080 that included the staff vaccination critical elements at the facility from 03/16/2022 to 03/17/2022. During the survey, the SA determined that the facility followed Medicare and Medicaid regulations for participation. The complaint for MS00017941 related to allegations of missing resident personal items, not being groomed adequately, body odor, and care not being received as physician ordered were unsubstantiated and MS00018080 related to allegations of missing resident personal items, admission and discharge rights, inappropriate feeding assistance, resident safety falls, facility staffing, no pressure sore precautions, resident visitation and care not being received as physician ordered were unsubstantiated and no deficiencies were cited. The facility was licensed for 120 beds and had a census of 87 at the time of the survey.	F 000			

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

TITLE

(X6) DATE

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 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.