STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255229	A. Building B. Wing	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, MS 38635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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 (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 [DATE] 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 [DATE] 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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 [DATE] 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission Record indicated Resident #27 was admitted to the facility on [DATE] 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 [DATE] 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.