STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255172	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starkville Manor Health Care and Rehabilitation Ce	1001 Hospital Road Starkville, MS 39759

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, and record review, the facility failed to ensure the dignity of a resident that needed supervision and/or assistance with meals for one (1) of five (5) residents reviewed during dining. Resident #4.Findings IncludeDuring an observation of the lunch tray pass in the dining room on 9/8/25 at 11:52AM, Resident #4 received his lunch tray from staff as he was sitting in his wheelchair at the table. This observation revealed the resident had no use of his right upper extremity. The meal that was provided included chicken stir-fried rice, a roll, watermelon in a small bowl, and a glass of tea. The resident was observed attempting to feed himself with a fork using his left hand. He repeatedly dropped his fork, had difficulty scooping food from the plate to his mouth, and began using his left fingers to eat. Food was observed spilling onto his clothing and the floor and when he picked up his tea glass, his hand was shaking which caused the tea to spill on his t-shirt and pants. He also had difficulty setting the tea glass back on the table and instead rested it on his leg. There was no observed assistance from the five staff members present in the dining room at the time. After attempting to eat with his left hand, he ate only a few bites and left the table by self-propelling himself down the hall with his left hand.An interview on 9/08/25 at 12:10 PM with the Certified Nurse Aide (CNA) #1 confirmed that staff were responsible for supervising residents during mealtimes and acknowledged that if a resident had trouble feeding themselves, staff should help.An interview on 9/09/25 at 1:34 PM with the Rehab Director confirmed that if Resident #4 had trouble feeding himself then staff should have stepped in and assisted.An interview with the Certified Occupational Therapy Assistant (COTA) on 9/9/25 at 1:50 PM revealed that with Resident #4 having to eat with his hands, it was a dignity concern.An interview with the Administrator on 9/09/25 at 2:42 PM revealed that it was her expectation for staff to provide supervision and assistance at mealtimes for residents who required it.A record review of the admission Record revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side, and Need for Assistance with Personal Care.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Section GG revealed the resident had upper extremity impairment in range of motion on one side.

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

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(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. Based on observation, family and staff interviews, record review, and facility policy review, the facility failed to implement a care plan for the application of a splinting device (Resident #4) and failed to implement a resident's ADL (activities of daily living) care plan related to personal hygiene and grooming (Resident #29) for two (2) of 21 resident care plans reviewed. Resident #4 and #29. F656 was cited on the last annual survey, therefore the scope and severity is increased to E. Findings Include: Review of the facility policy titled, Plans of Care dated 06/01/25 revealed, Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team as determined by the resident's needs or as requested by the resident Resident #4 Record review of Resident #4's Care Plan Report revealed under, Focus: I have right dominant side hemiplegia/hemiparesis R/T (related to) CVA (cerebrovascular accident) Also revealed under, Interventions: Resting right hand splint 4 (four) hours daily. CNA (certified nurse aide) to apply and remove, nurse to check. Monitor right hand daily for s/s (signs and symptoms) of skin breakdown before and after splint removal every day shift. On 9/08/25 at 11:52 AM and again on 9/09/25 at 10:32 AM, an observation of Resident #4 revealed he was sitting in his wheelchair without a hand splint. During an interview with Licensed Practical Nurse (LPN) #1 on 9/09/25 at 2:00 PM, he confirmed he did not apply Resident #4's hand splint on 9/8/25 or 9/9/25 and did not follow the plan of care. An interview with the Minimum Data Set (MDS) Nurse on 9/10/25 at 8:40 AM revealed the purpose of the care plan was to ensure the staff performed the care the resident needed. She revealed if Resident #4's splint was not applied his care plan was not followed. Record review of the admission Record revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, and Need for Assistance with Personal Care. Record review of the MDS with an Assessment Reference Date (ARD) of 9/05/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Resident #29 Record review of Resident #29's Care Plan Report revealed that she was dependent on staff for meeting emotional, intellectual, physical, and social needs and that she had an ADL (Activities of Daily Living) self-care performance deficit and required total assistance with personal hygiene. (continued on next page)

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(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	During an observation and interview on 09/09/25 at 8:05 AM with Resident #29's Resident Representative (RR), she revealed that it had been a while since the staff had washed her (Resident #29) hair. RR revealed that Resident #29's hair was dirty and matted up and stated, they need to do better. An observation revealed a large amount of thick light brown crusty substance on her scalp, over her entire head and throughout her hair. An observation and interview on 09/09/25 at 8:20 AM with Certified Nursing Assistant (CNA) #2, revealed that she hadn't washed Resident #29's hair in about two weeks. CNA #2 confirmed that Resident #29's hair was matted up and that her hair should be washed and brushed more often. During an observation and interview on 09/09/25 at 9:00 AM with Assistant Director of Nursing (ADON) in Resident #29's room, she confirmed that Resident #29 had a thick brown crusty substance in her hair and confirmed that her hair was matted. The ADON confirmed that personal hygiene included hair washing and grooming and should be completed on bath or shower days unless otherwise indicated, and since Resident #29's hair had not been washed or brushed recently, her care plan was not followed. An interview with MDS Nurse, on 09/10/25 at 8:45 AM, revealed that it was their expectation for residents to get their hair washed on their scheduled shower days three times a week unless otherwise specified. She confirmed that since Resident #29's hair had not been washed on a regular basis, her care plan was not followed. Record review of Resident #29's admission Record revealed an admission date of 07/15/21 and that she had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care. Record review of Resident #29's MDS with an ARD of 07/30/25 under Section C, revealed a BIMS score of 03 which indicated that she had severe cognitive deficits.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, record review and facility policy review, the facility failed to provide assistance with meals (Resident #4) and failed to provide personal hygiene and grooming for a dependent resident (Resident #29) for two (2) of 106 residents residing in the facility. Resident #4 and Resident #29. F677 was cited on the last annual survey, therefore the scope and severity was increased to E. Findings Include: Review of the facility policy Activities of Daily Living (ADLs) dated 06/01/25 revealed, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care 4. Eating to include meals and snacks Resident #4 An observation on 9/8/25 at 11:52AM in the dining room revealed Resident #4 sitting in his wheelchair at the table, with no use of his right upper extremity. He was provided a meal of chicken stir-fried rice, a roll, watermelon in a small bowl, and a glass of tea. The resident was observed attempting to feed himself with a fork using his left hand. He repeatedly dropped his fork, had difficulty scooping food from the plate to his mouth, and began using his left fingers to eat. Food was observed spilling onto his clothing and the floor and when he picked up his tea glass, his hand was shaking which caused the tea to spill on his t-shirt and pants. He also had difficulty setting the tea glass back on the table and instead rested it on his leg. There was no observed assistance from the five staff members present in the dining room at the time. After attempting to eat with his left hand, he ate only a few bites and left the table by self-propelling himself down the hall with his left hand. An observation and interview with Resident #4 on 9/08/25 at 12:05 PM revealed he was sitting in his wheelchair and propelling himself toward his room. When asked whether he got enough to eat, the resident shook his head No. An interview on 9/08/25 at 12:10 PM with the Certified Nurse Aide (CNA) #1 confirmed that staff were responsible for supervising residents during mealtimes and acknowledged that if a resident had trouble feeding themselves, staff should help. She stated that Resident #4 could feed himself. An interview on 9/09/25 at 1:34 PM with the Rehab Director confirmed that Resident #4 had returned from the hospital recently with a physical decline and admitted that he was on the occupational therapy caseload. She explained that he had positioning concerns due to his stroke. The Rehab Director stated the resident should be allowed to feed himself, but if he had trouble, staff should step in and assist. She confirmed the resident could lose weight if he missed meals and stated the dining room staff should have intervened. An interview with the Administrator on 9/09/25 at 2:42 PM acknowledged Resident #4 could lose weight if staff failed to assist if he was having trouble. She revealed that it was her expectation for staff to provide supervision and assistance at mealtimes for residents who required it. A record review of the admission Record revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side, and Need for Assistance with Personal Care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Section GG revealed the resident had upper extremity impairment in range of motion on one side. Resident #29 On 09/09/25 at 8:05 AM during an observation and interview with Resident #29'and her Resident Representative (RR), the resident was sitting in her wheelchair, and the RP was using a comb with a pan of soapy water to comb through the resident's hair. The RR stated that it had been a while since the staff had brushed or washed her (Resident #29) hair. She revealed that Resident #29's hair was dirty and matted up and stated, they need to do better. An observation of Resident #29's hair confirmed there was a large amount of a thick light brown crusty substance to the resident's scalp, over her entire head and throughout her hair with matted knots of hair. The RR revealed she was trying to comb out the knots and remove the brown substance from her hair and stated, She has beautiful hair and I'm thinking about cutting it because of this. The RR then revealed that this was not the first time this had happened and admitted that she had given them the opportunity to wash her hair, but they did not. She revealed that when she reports this to the staff, they take care of it for a moment and then it gets back like it was. An observation and interview on 09/09/25 at 8:20 AM with CNA #2 she stated, Her daughter will let me know when she wants it done. She admitted that it had been two weeks since she had washed Resident #29's hair. She then confirmed that Resident #29's hair was matted up and had a large amount of brown crusty substance on her scalp and throughout her hair and admitted that it should be washed and brushed more often. An observation of Resident #29 and interview with the Assistant Director of Nursing (ADON) on 9/9/25 at 9:00 AM confirmed the resident had a thick brown crusty substance on her scalp and throughout her hair and that her hair was matted. She stated, This is not okay. She admitted that the crusty buildup on Resident #29's head could cause itching and the skin to break down. She also revealed that hair washing should be completed during bath or shower time as part of her grooming needs. Record review of Resident #29's admission Record revealed an admission date of 07/15/21 and that she had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care. Record review of Resident #29's MDS with an ARD of 07/30/25 under Section C, revealed a BIMS score of 03 which indicated that she had severe cognitive deficits and under Section GG revealed that she was dependent on staff to provide personal hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and staff interview, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent a decline in range of motion (ROM), as evidenced by the failure to apply a physician-ordered hand splint for one (1) of four (4) residents reviewed for ROM. Resident #4Findings Include: The facility provided a statement on letterhead dated 9/10/25 and signed by the Administrator, We do not have a specific policy related to splints. Record review of Resident #4's September 2025 Treatment Administration Record (TAR) revealed an order dated 4/15/25: Resting right hand splint 4 (four) hours daily. CNA (Certified Nurse Aide) to apply and remove, nurse to check. Monitor right hand daily for s/s (signs and symptoms) of skin breakdown before and after splint removal every day shift and was documented that the splint was applied at 9:00 AM on 9/8/25 and 9/9/25. An observation of Resident #4 on 9/08/25 at 11:52 AM and again on 9/09/25 at 10:32 AM revealed he was sitting in his wheelchair without a hand splint. An interview with CNA #3 on 9/09/25 at 1:31 PM revealed she was assigned to Resident #4 today. She stated the resident had not been wearing a hand splint and she was not aware she was supposed to apply one. An interview with the Rehab Director on 9/09/25 at 1:38 PM revealed Resident #4's hand splint was ordered during a previous therapy session to prevent his right-hand contracture from worsening. She explained that the occupational therapist (OT) had trained and educated staff on how to apply the splint before the resident's therapy discharge. She confirmed that if the resident was not wearing the splint, his contracture could worsen. Record review of Resident #4's Therapy Follow-Up Recommendation dated 4/10/25 confirmed under Overall Goals: Prevent contractures in right hand and place hand in optimal functional position. Documentation revealed that the occupational therapist conducted a staff in-service training on applying the hand splint, with staff signatures recorded. An interview with Licensed Practical Nurse (LPN) #1 on 9/09/25 at 2:00 PM confirmed he did not apply Resident #4's hand splint on 9/8 or 9/9. He acknowledged signing the treatment administration record (TAR) and explained there was miscommunication regarding who was responsible for applying the splint. He confirmed that not applying the splint as ordered could cause worsening contractures. An interview with the Administrator on 9/09/25 at 2:42 PM revealed her expectation was for splinting devices to be applied according to physician orders. Record review of the admission Record revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, and Need for Assistance with Personal Care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Section GG also revealed upper extremity impairment in range of motion on one side.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, staff interview, and facility policy review, the facility failed to ensure complete and accurate staffing data was submitted to the Centers for Medicare & Medicaid Services (CMS) through Payroll-Based Journal (PBJ) reporting during Quarter 3 of Fiscal Year (FY) 2025 (April 1 - June 30). Findings include: Review of the facility policy titled, Payroll Based Journal, implemented 6/1/25, revealed:Policy: It is the policy of the facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS . Review of the facility's PBJ Staffing Data Report revealed the facility triggered for low weekend staffing for FY Quarter 3 2025 (April 1 – June 30). Review of the PBJ hours submitted for 6/8/25, 6/15/25, 6/22/25, and 6/28/25 revealed fewer direct care staff hours submitted than documented on the facility staffing grid. 6/8/25: PBJ submitted 301.98 hours; staffing grid documented 317 actual hours. 6/15/25: PBJ submitted 312 hours; staffing grid documented 327.75 actual hours. 6/22/25: PBJ submitted 315.80 hours; staffing grid documented 322.68 actual hours. 6/28/25: PBJ submitted 317.45 hours; staffing grid documented 325.42 actual hours. During an interview with the Administrator on 9/10/25 at 7:49 AM, she confirmed that on those four dates, on-call salaried administrative nursing staff worked but their hours were not included in the PBJ data submitted to CMS and confirmed their hours should have been included. She stated the purpose of accurate PBJ reporting is to provide an accurate depiction of the number of staff available to provide quality care to the residents.