STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILITATION CENTER	**1001 HOSPITAL ROAD , STARKVILLE, Mississippi, 39759**

(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 recertification survey and complaint investigations (CI) MS# 3053540 and CI MS# 3067819 at the facility from 07/13/26 through 07/15/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F800. CI MS# 3053540 and CI MS# 3067819 were investigated with no deficiencies cited. The facility had a census of 99 and was licensed for 119 beds.	F0000		
F0800 SS = D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident, staff, and dialysis staff interview, record review, and facility policy review, the facility failed to provide an individualized therapeutic renal diet by failing to assess and incorporate the resident's food preferences into a therapeutic diet for one (1) of four (4) residents reviewed for the dining task. Resident #4. Findings Include: Review of the facility policy titled “Dining and Food Preferences” revised 9/25 revealed “Policy Statement: Individual dining, food, and beverage preferences are identified for all residents/patients.” Additionally revealed under, “Procedures: …2. The Dining Services Director or designee will interview the resident or resident representative to complete a Food Preference Interview within 72 hours of	F0800		

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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F0800 SS = D	Continued from page 1 admission…. 4. Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software. 5. The Registered Dietician/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents/patients that do not consume certain foods or food groups…. 7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences..." Record review of Resident #4's "Order Details" revealed an order dated 4/28/26, "Hemodialysis at (proper name of dialysis company) M (Monday), W (Wednesday), F (Friday) at 12." Record review of the Order Summary Report revealed an order dated 4/28/26, "Renal diet Regular texture, Regular/Thin liquids consistency…" An interview with Resident #4 on 7/14/26 at 8:10 AM revealed he was receiving dialysis and had food related concerns. He revealed he received the same breakfast every morning which included scrambled eggs, oatmeal, and a piece of bread right out of the loaf, not toasted or buttered. Resident #4 revealed he never gets any meat and stated he could not remember the last time he received meat for breakfast. The resident stated that he orders food from outside restaurants and has a lot of his meals delivered because he was not satisfied with the meal and gets hungry. During a dining observation on 7/14/26 at 11:38 AM, Resident #4 received his lunch meal in his room and was served cheese lasagna, buttered toast, small side salad and sliced apples. Resident voiced he disliked the meal and requested the chicken tenders off the alternate menu. An observation and interview with Licensed Practical Nurse (LPN) #1 on 7/14/26 at 11:44 AM, she was notified of the resident's dislike for cheese lasagna and request for chicken strips. She stated the kitchen probably did not have any, but she would ask. She revealed they only cook so much of the alternate menu and the resident must make his choice by early morning. LPN# 1 stated the resident liked to sleep in, so most of the time he could not get the alternate. An observation of the breakfast meal on 7/15/26 at	F0800		

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F0800 SS = D	Continued from page 2 7:30 AM revealed the resident ate in his room. The meal provided was 1/4 (one-fourth) cup of scrambled eggs, a piece of plain bread untoasted with no butter, 6-ounce bowl of cream of rice cereal, and ½ (one-half) cup of grapes, with no butter or jelly added on the tray. The resident stated he was not going to eat the piece of bread or the rice cereal and would only eat the eggs. The resident reiterated this was the same meal that he received every morning. Record review of the breakfast “Meal Ticket” provided with the meal revealed “Renal Diet" with no indication of the residents like and dislikes or meal preferences. An observation and interview with the Dietary Accounts Manager on 7/15/26 at 7:42 AM revealed she oversaw the dietary department and was responsible for getting the meal preferences of the residents. She explained that she had been working in the kitchen for three (3) years but took over this position on Sunday. She stated she had not started interviewing the residents about their meal preferences yet but had it on her list of things to do, confirming no preferences were listed on Resident #4’s meal ticket. She confirmed the resident received a plain piece of bread and stated, “It must have got mixed up because I toasted his piece.” She explained the facility had a preplanned renal diet plan that the kitchen followed, and the resident was only allowed certain foods, confirming the diet restricted breakfast meats. She confirmed that he should have gotten more than a 1/4 cup eggs though and she wasn't sure that this would meet his daily protein goals. She confirmed the residents’ preferences were not met, further revealing the resident would have to speak with the Director of Nursing (DON) to sign a waiver to get the foods he preferred. A telephone interview with the “Proper name of dialysis Registered Dietician (RD)” on 7/15/26 at 8:52 AM she stated she was not opposed to the resident having meat with breakfast, but she indicated there had been some issues with the facility in the past regarding breakfast meats, so she did not interfere. She stated “We need to be as less restrictive as we can” revealing she was not aware the resident was having meals delivered to the facility. She confirmed the facility RD had not contacted her about anything concerning the resident’s diet. A telephone interview with Registered Dietician (RD) on 7/15/26 at 10:25 AM revealed the last time she	F0800		

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F0800 SS = D	Continued from page 3 evaluated the resident was in April, although she reviewed his information and documented on him monthly. The RD stated she did not discuss any preferences with the resident because she would have emailed it to the kitchen, so the meal ticket could be updated. She stated the resident could always let the kitchen know and they could update his preferences. Record review of the RD “Medical Nutrition Therapy (MNT) Notes” dated 5/21/26, 6/4/26, and 7/6/26 reflected routine monitoring of weight, laboratory values, and diet orders; however, the RD had not evaluated the resident since April despite completing routine monitoring notes. There was no evidence an assessment was completed for preferences. Record review of the “Nutrition Evaluation Initial, Annual and Significant Change” dated 4/30/26 revealed there was not documentation the RD discussed preferences with the resident. Record review of the “Admission Record” revealed the facility re-admitted Resident #4 on 4/28/26 with medical diagnoses that included Type 2 Diabetes Mellitus Without Complications, Familial Hypophosphatemia, Hypo-Osmolality and Hyponatremia, End Stage Renal Disease, and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #4 was cognitively intact.	F0800		