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| ASHLAND HEALTH AND REHABILITATION | 16056 BOUNDRY DRIVE ASHLAND, MS 38603 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted an annual recertification survey at the facility from 11/19/23 through 11/21/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation with Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M 500 and M 1570.<br><br>The facility held a license for 60 beds, with a census of 45. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>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;<br><br>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;<br><br>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 | M 500 | | 12/15/23 |

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| M 500 | Continued From page 1<br>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 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;<br><br>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;<br><br>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;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial | M 500 | | |

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| M 500 | Continued From page 2 | M 500 | | |

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 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,

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| M 500 | Continued From page 3<br>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);<br><br>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);<br><br>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);<br><br>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<br><br>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 exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff and resident interview, record review and facility policy review the facility failed to prevent a resident from being physically restrained by the sound of a chair alarm for one (1) of three (3) residents with chair | M 500 | 1. Corrective action was completed on Resident #23 by removing clip alarm on 11-20-2023. Resident was re-assessed by Director of Nursing on 11-20-23 after resident interview and resident's request | |

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| M 500 | Continued From page 4<br>alarms reviewed. Resident #23.<br><br>Findings include:<br><br>Review of the facility policy titled, "Restraint Standards; Physical Restraints" with a revision date of 4/2023 revealed under, "Physical Restraints Standard ...The goal of this facility is to ensure that each resident attains and maintains his/her highest practical level of function and well-being in an environment that limits restraint use to circumstances in which the medical symptoms of the resident warrant the use of the least restrictive restraint".<br><br>On 11/19/23 at 3:40 PM, an observation and interview revealed a chair alarm on Resident #23's wheelchair that was pinned to the back of her shirt. This observation revealed the resident propels herself with her feet in the wheelchair. During an interview at the same time with Resident #23 revealed that the resident is alert to herself and pleasantly confused on time and place. Resident #23 was asked if she knew what the device was on her wheelchair and she stated, "It's a woolly of a thing, it worries me to death. It's supposed to catch me if I'm about to fall. I ask them all the time if I can get it off there and they say no ma'am".<br><br>An interview on 11/20/23 at 9:00 AM with Certified Nurse Assistant (CNA) #1 confirmed that Resident #23 has a chair alarm clipped to her shirt and connected to a box device on her wheelchair. She stated that she thinks they put it on there because the resident kept falling. She stated that the alarm goes off when she tries to get up or when she moves forward enough in her wheelchair that makes it alarm. She stated that the resident really doesn't like the chair alarm and | M 500 | for alarm to be removed.<br><br>2. Six of the residents residing at the facility have been assessed at a high risk for falls could be affected by the same practice of utilizing a clip alarm. Clip alarms were removed on Resident #23 and Resident #24 after resident interview, and RN assessment, and discussion of residents with clip alarms during an Interdisciplinary Team (IDT) meeting on 11-19-23. The IDT consists of Nursing Home Administrator,Director of Nursing, Nurse Educator, Medical Records LPN, RN Supervisor, MDS RN.<br>An audit was performed by Director of Nursing (DON) and Nurse Educator (NE) on the six residents that had clip alarms on 11-20-2023. The audit performed noted for MD order, family aware of clip alarm, clip alarm documented on Medication Administration Record (MAR), and resident agrees with placement of clip alarm for safety. If clip alarm is deemed appropriate but resident does not agree then would be deemed a restraint and the Restraint Standard to be followed.<br>Findings of initial audit noted that clip alarm was not documented on the MAR, and note had not been made that resident agreed with placement of clip alarm for six of the six clip alarms.<br><br>3. To ensure that utilizing a physical restraint inappropriately does not reoccur an inservice was begun on 11-19-23 by Nurse Educator and completed on 11-21-23 for nursing staff on proper documentation, appropriate interventions of MD order, resident agreement with | |

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| M 500 | Continued From page 5<br>has complained about wanting it removed. She confirmed that she had told Registered Nurse (RN) #2 about the resident's complaint of wanting the clip alarm removed.<br><br>An interview on 11/20/23 at 9:05 AM with CNA #2 confirmed that Resident #23 had complained several times about not wanting the clip alarm on her wheelchair.<br><br>On 11/20/23 at 10:30 AM, an interview with RN Minimum Data Set (MDS) nurse confirmed that Resident #23 had a clip alarm on her wheelchair because she kept falling. She revealed that the Interdisciplinary Team (IDT) team decides who gets a clip alarm when they discuss in the morning standup meetings regarding falls. She stated that they do not consider it a restraint because the resident can remove it. She revealed that when a resident has a fall then a fall risk assessment is completed that indicates the use of a clip alarm. She stated that normally they will leave the alarm on for a couple of months then reevaluate with a high risk fall assessment. She stated she has not heard of any resident's complaining but if they did then they would have to re-evaluate, educate, and possibly do another alternative to the alarm.<br><br>On 11/20/23 at 10:40 AM, an interview with the Director of Nurses (DON) and Nurse Educator confirmed that Resident #23 did have a clip alarm on her wheelchair and has had it since her last fall in 8/2023. The Nurse Educator revealed that the resident's fall prior to the one in 8/2023 occurred in 4/2023 and the resident did not have any injuries with either fall. She confirmed that they do not necessarily consider the clip alarm on the wheelchair to be a restraint because the resident can remove it. She stated that they | M 500 | placement of clip alarm for safety, family aware of clip alarm, that clip alarm is noted on MAR. Inservice on 11-20-23 included instruction if clip alarm is noted by resident to be a restraint but deemed necessary for resident safety by Interdisplinary Team (IDT), Restraint Standard would be followed. IDT will note all clip alarms on white board during facility morning meetings noting appropriate interventions have been followed and are in place. All new hires for nursing will be inserviced by the Nurse Educator on this process and it will be ongoing.<br><br>4. To ensure that the facility has sustained compliance, beginning 11-19-23 the resident's nurse and the resident's certified nurse aide will monitor during every two hour staff rounds and note on the MAR and the CNA Task List that the clip alarms are in place on the four residents with clip alarms. The IDT will audit weekly beginning 11-22-23 and note in the Quality Assurance Performance Improvement (QAPI) minutes durng their weekly QAPI meeting that appropriate interventions are in place and will re-evaluate monthly for need for clip alarm. This will be ongoing.<br>On 12-14-23 a report was submitted for discussion by the Director of Nursing to the Quality Assurance Performance Improvement (QAPI) team noting all clip alarms and documentation. THE QAPI team consists of Medical Director,Nursing Home Administrator,Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping | |

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| M 500 | Continued From page 6<br><br>usually leave the clip alarm on the resident for 2 months then reevaluate with a high risk fall evaluation again to determine if the resident still needs the alarm. She confirmed that they would normally discuss this reevaluation in the IDT meetings then remove the alarm and see how the resident does. The DON and the nurse educator confirmed that if a resident complained about the clip alarm and did not want it on, then they would need to reevaluate and remove. The DON stated that if the resident complained about the alarm to staff, then they should notify us so we can reevaluate.<br><br>An observation and interview on 11/20/23 at 11:00 AM, with the DON, Nurse Educator and Resident #23 the resident confirmed that she did not like the alarm on her chair, that every time she moved it went off, she could not even get her books out of her dresser drawers without it going off and buzzing. She stated she knew it was because she had fallen and she may fall tomorrow, but she wanted it taken off. The DON and the Nurse Educator agreed that they would reassess the residents need for the clip alarm.<br><br>An interview on 11/20/23 at 3:00PM, with the Administrator revealed that she felt like it was a hard call to make whether the residents need a chair alarm or not. She stated that she would consider the residents diagnoses and cognition when determining if a resident needed the alarm due to falls. She agreed that if a resident was complaining about not wanting the alarm, then they should reassess the need.<br><br>An interview on 11/21/23 at 8:44 AM, with the DON confirmed that she understands that assessing the resident for how they feel about the chair alarm should be part of the assessment for | M 500 | Supervisor, Nurse Educator, Human Resource Director, Activity Director, and Maintenance Director.<br>The QAPI team will review and monitor this process until 100% compliance has been obtained for three months.<br><br>The Director of Nursing is responsible for compliance. | |

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| M 500 | Continued From page 7 | M 500 | | |

its use. She stated that they just really did not consider it a restraint, or they would have done things differently. She revealed that she understood after reading the regulation that it can be considered a restraint. She revealed that they probably need to have an order for any type of alarm use, document the reason for the use of the alarm and the reevaluation documented along with coding it correctly on the MDS and care planning it correctly also. She confirmed that the resident's fall evaluations dated 8/2023 and 9/2023 did not indicate the use of a chair alarm.

Record review of Resident #23's "Incident Investigation" form dated 8/23/23 revealed the resident had an unwitnessed fall with no injuries.

Record review of Resident #23's "Fall Evaluation" form dated 8/23/23 and 9/1/23 revealed under "clinical suggestions" that positioning alarms were not indicated.

Record review of Resident #23's progress notes revealed there was a note dated 9/14/23 that indicated the resident was being evaluated for a chair clip alarm. This review revealed no other documentation regarding the alarm.

Record review of Resident #23's "Admission Record" revealed the resident was admitted to the facility on 8/31/22 with medical diagnoses that included Type 2 Diabetes Mellitus without Complications.

Record review of Resident #23's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident is severely cognitively impaired and in Section P

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| M 500 | Continued From page 8<br>that the resident had a chair alarm in use at all times. | M 500 | | |
| M1570 | 48.58.1 Infection Control<br><br>The following infection control standards shall be met:<br><br>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.<br><br>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.<br><br>3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observations, record reviews, and facility policy reviews the facility failed to clean and disinfect a multi-use glucometer with the approved disinfecting wipe for two (2) of two (2) | M1570 | 1. Corrective action was completed by Nurse Educator inservicing on 11-19-23 LPN #3 and LPN #4 on immediately cleaning multi-use glucometer with Micro-Kill Bleach Germicidal wipes and by cleaning multi-use glucometer with Bleach | 12/15/23 |

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| M1570 | Continued From page 9<br>medication carts reviewed.<br><br>Findings include:<br><br>Record review of the policy titled, "Diabetic Management," dated 04/2019, revealed, "Cleaning and disinfecting your EvenCare G2 Meter: ...4. To disinfect your meter, clean the meter surface with one of the following disinfecting wipes: Dispatch Hospital Cleaner Disinfectant Towel with Bleach (1 minute). Medline Micro-Kill Disinfecting, Deodorizing, cleaning wipes with Alcohol (30 seconds). Clorox Healthcare Bleach Germicidal and Disinfectant Wipes (1 minute). Medline Micro-Kill Bleach Germicidal Bleach Wipes (2 minutes)..."<br><br>An observation and interview on 11/19/23 at 4:10 PM, with Licensed Practical Nurse (LPN) #4, the LPN used the glucometer to check finger stick blood sugar (FSBS) of a resident and upon return to the B hall medication cart LPN#4 retrieved a pack of 75% alcohol disinfecting wipes and wiped the glucometer with the alcohol wipe for about 15 seconds and laid the glucometer down on a napkin with the wipe still wrapped around the glucometer. An interview with the LPN at this time stated that she usually uses the purple top wipes but there weren't any on her med cart for the last two days and stated, "I think we are out of them. I looked for them yesterday and couldn't find any."<br><br>An observation and interview on 11/19/23 at 4:15 PM, with LPN #3 on A hall med cart revealed that she was out of the purple top wipes as well and stated, "I told the Registered Nurse (RN) supervisor to bring me some wipes and he brought me these," holding up a container of 75% alcohol disinfecting wipes. LPN #3 confirmed that she works every other weekend and has not had | M1570 | germicidal wipes. On 11-19-23 Nurse Educator provided additional information with return demonstration of LPNs' #3 and #4 on proper technique of disinfecting multi-use glucometer.<br><br>2. All residents at the facility that utilize a multi-use glucometer have the potential for transmission of communicable disease or infection. 100% audit was performed by Nursing Home Administrator of resident with diagnosis on 11-19-21, documentation determined no resident currently residing in facility had a communicable blood borne pathogen diagnosis. On 11-19-23 bleach wipes were placed on LPN's #3 and #4 medication cart, Supply Room, and additional bleach wipes placed in Med Room by Director of Nursing. On 11-19-23 additional nurses at facility were inserviced by Nurse Educator regarding proper technique for sanitizing multiuse glucometer. Beginning 11-19-23 nurses and Supply clerk were inserviced that germicidal wipes should be on medication cart, in Med Room and Supply Room, and if nurse cannot locate wipes, they are to immediately notify Director of Nursing or the Nursing Home Administrator.<br><br>3. To ensure that proper technique for sanitizing multi-use glucometer occurs, inservices were completed on 11-19-23 by Nurse Educator or Director of Nursing for LPN #3 and LPN #4. Inservices by the Nurse Educator beginning on 11-19-23 and completed by 11-21-23 for all nurses that are employed by facility on proper disinfecting technique of multi-use | |

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| M1570 | Continued From page 10<br>any purple top wipes on her med cart yesterday or today, but did have some the last time she worked.<br><br>Interview on 11/19/23 at 4:18 PM, with the CNA Staffing Coordinator confirmed that she ordered supplies and stated, "I think they (purple top wipes) are on back order, let me check the supply closet." Observation of the supply closet with CNA staffing coordinator confirmed that there were no purple top wipes in the supply closet.<br><br>An interview with the Director of Nursing (DON) on 11/19/23 at 4:20 PM, confirmed that she had the disinfecting wipes for the glucometers in her office and that they had just come in and she had placed them in her office, not knowing that the nurses on the med carts were out and that there were none available in the supply closet. The DON confirmed that her office is locked and that weekend staff would not have had access to her office to retrieve the wipes.<br><br>Record review of in-services transcript for LPN #4 revealed that she had "Diabetic Management" and "Infection Control," on 10/30/23 and LPN #3 completed her in-service titled, "Glucometer Disinfection" on 10/26/23.<br><br>An interview with the DON on 11/20/23 at 2:35 PM, confirmed that these three inservices that were attended by LPN #3 and LPN #4 would have taught them that they have to use a germicidal wipe instead of an alcohol wipe on the glucometers.<br><br>Interview on 11/20/23 at 2:40 PM, with the Nurse Educator confirmed that the in-services titled "Glucometer Disinfection" and "Diabetic Management," is the same in-service and training | M1570 | glucometer as noted by successful return demonstration. LPN #3 and LPN #4 will perform return demonstration of proper disinfecting technique of multi-use glucometer weekly beginning 11-19-23 with return demonstration observed for next 4 weeks to the Nurse Educator. Beginning 11-20-23 Central Supply Clerk will note that germicidal wipes are in medication carts, available in Med room and Supply room during the week and adequate supplies for the weekend are noted on Fridays. Central Supply clerk to notify Director of Nursing or Nursing Home Administrator immediately if there is any type of supply issue.<br>All new nurses will be educated by the Nurse Educator upon hire and ongoing in regards to supplies needed for work.<br><br>4. To ensure that the facility has sustained compliance, beginning 11-21-23 audits of supplies will be performed by the Central Supply clerk biweekly for six weeks,then weekly and then ongoing. Any issues with germicidal wipes will be immediately reported to the Director of Nursing or Nursing Home Administrator. Results of supply audit will be reported by the Director of Nursing for discussion to the Quality Assurance Performance Improvement (QAPI) team beginning 12-14-23 and then monthly for three months. The QAPI team consists of Medical Director,Nursing Home Administrator,Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping Supervisor, Nurse Educator, Human Resource Director, Activity Director, and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05BE | A. BUILDING: _____ B. WING _____ | 11/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ASHLAND HEALTH AND REHABILITATION | 16056 BOUNDRY DRIVE ASHLAND, MS 38603 |

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| M1570 | Continued From page 11<br>on how to clean the meter with the appropriate wipe. | M1570 | Maintenance Director.<br>The Nurse Educator will audit proper cleaning technique of multi-use glucometer with germicdal wipes beginning 11-21-23 weekly times four weeks for LPN #3 and LPN #4 and will be ongoing for nurses newly hired. Results of proper cleaning technique of multi-use glucometer audit will be reported by the Director of Nursing to the Quality Assurance Performance Improvement (QAPI) team for discussion beginning 12-14-23 and monthly until 100% compliance has been obtained for three months. The QAPI team consists of Medical Director,Nursing Home Administrator,Director of Nursing, Medical Records LPN, Social Service, Dietary Manager, Housekeeping Supervisor, Nurse Educator, Human Resource Director, Activity Director, and Maintenance Director.<br><br>The Director of Nursing is responsible for compliance. | |