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	70RH	A. BUILDING: _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #24539 at the facility from 4/23/24 through 4/25/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M610, M640 and M1570. The SA determined that the facility was in compliance related to CI MS #24539.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, and facility policy review, the facility failed to perform nail care for a resident that needed assistance, as evidence by long thick fingernails for one (1) of two (2) residents reviewed for activities of daily living (ADLs). Resident #24 Findings Include:	M 610	1. On 04.23.2024, Registered Nurse provided nail care for Resident #24 nails. 2. On 04/29/2024, The facility Administrator and Director of Nursing noted that 42 out of 42 residents who reside in the facility had the potential to be affected by this allegation of deficient practice of not providing nail care. 3. On 05.03.24, the Director of Nursing completed an audit of 42 of 42 residents. 16 out of 16 Diabetic residents had an order updated for a Licensed Nurse to	5/18/24

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M 610	Continued From page 1 Review of the facility policy titled "Care of Fingernails/Toenails" with a revision date of 06/2022 revealed under, "Purpose: The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections. Nail care includes cleaning and trimming as needed. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/her skin (unless medically contraindicated)". Resident #24 An observation and interview on 4/23/2024 at 9:50 AM, with Resident #24, revealed long thick discolored fingernails on the left hand that measured approximately three-eights (3/8) inch in length from the tip of the fingers. The nails on the right hand measured approximately one-fourth (1/4) inch in length. The resident expressed he "would like his nails cut". An observation and interview with Licensed Practical Nurse (LPN) #6 on 4/23/2024 at 2:20 PM, confirmed Resident #24's nails needed cutting. She revealed a Registered Nurse (RN) must cut his nails because he was a diabetic. An observation and interview with Registered Nurse (RN) #1 on 4/23/2024 at 2:39 PM, revealed she was responsible for trimming the diabetic nails. She confirmed Resident #24's nails were long, and he could scratch himself and cause skin concerns. An interview with the Director of Nursing (DON) on 4/24/2024 at 8:14 AM revealed the Registered Nurse (RN) on duty was responsible for doing nail care for the diabetics every Tuesday, and it	M 610	complete nail care. 26 of 26 non-diabetic residents' nail care is to be provided by a Certified Nursing Assistant(CNA) in the shower and documented on Point Of Care(POC). On 05.03.2024, the Nurse Educator provided an in-service to 15 of 15 nurses and 17 of 17 CNAs on the Activity of Daily Living(ADL) Care Standard. 4. The Director of Nursing is to monitor Medication Administration Record(MAR)/ Treatment Administration Record(TAR) documentation and Point Of Care documentation weekly for 30 days beginning on 04.29.24 and monthly for three months ending on 07.29.24 to ensure completion of documentation. The Medical Records Coordinator, Nurse Educator, Dietary Manager, Activity Director, and Minimum Data Set(MDS) Coordinator to complete weekly rounds on Thursdays beginning 04.29.24 and then monthly for 3 months with completion on 07.29.24. The findings from these audits will be brought to our Quality Assurance Performance Improvement(QAPI) meeting on 05.16.2024 and then monthly for three months. The findings will be reviewed by the Interdisciplinary Team and the Quality Assurance(QA) committee which consists of which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director.	

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M 610	Continued From page 2 should be documented on the Medication Administration Record (MAR). She confirmed Resident #24 did not have this task on his MAR. She confirmed that the long nails were an infection and a personal hygiene concern.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to prevent the possibility of accidents and hazards for a resident who was an elopement risk by failing to monitor placement and function of a wander guard (Resident #1) and failure to secure smoking supplies for one (1) of three (3) days of survey. Findings Include Record review of the facility policy titled, "Wandering/Elopement Risk" with a revision date of 11/2017 revealed "STANDARD It is the standard of this facility to identify those residents at risk for wandering/elopement and to take the appropriate steps to minimize the risk of elopement ... The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or	M 640	1. On 04/24/24, an order was entered for Resident #1 for a wander guard for safety to include the monitoring and function on the MAR/TAR. On 05/09/2024, the care plan for Resident #1 was updated to include the monitoring and functioning of the wander guard. On 04/29/2024, an automatic locking doorknob was placed on the door of the smoking closet. 2. On 04/29/2024, The Facility Administrator and Director of Nursing noted that 42 of 42 residents who reside in the facility had the potential to be affected by this allegation of deficient practice of failure to keep residents free of accident hazards/supervision/devices. 3. All staff were in-serviced on 5/3/2024 by the facility Nurse educator on the facility standard Wandering/Elopement Standard and the facility Smoking Standard. 47 of 47 staff received in-service on the Wandering/Elopement	5/18/24

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M 640	Continued From page 3 unsafe wandering ..." of 10/2017 revealed "STANDARD This facility provides a safe and healthy environment for residents ...including safety as related to smoking. Safety protections apply to smoking and non-smoking residents ...Standard Explanation and Compliance Guidelines ...13. Smoking material will be maintained and secured by nursing staff ..." Resident #1 An observation on 04/23/24 at 12:49 PM, revealed Resident #1 was wearing a wander guard bracelet on his left wrist. Record review of Resident #1's "Elopement Evaluation" dated 3/11/24 revealed the resident has a history of elopement or attempted elopement and wanders. Record review of Resident #1's "Order Summary Report" with active orders as of 4/24/24 revealed there was not an order for a wander guard bracelet. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/24 revealed in Section P the resident was coded for a wander/elopement alarm that was used daily. An interview on 4/23/24 at 1:30 PM, with Registered Nurse (RN) #1 revealed that Resident #1 wears a wander guard because he has dementia and gets confused sometimes. She stated he says he wants to go home and does wander, but he has never eloped.	M 640	Standard and the facility Smoking Standard. All new hires will receive training upon hire in the orientation process. All new hires will be in serviced on the Wandering/Elopement Standard and the Activity of Daily Living (ADL) Care Standard before beginning patient assignments. All new hires will be in serviced on the Wandering/Elopement Standard and the facility Smoking Standard before beginning assignments. 4. The Director of Nursing or Minimum Data Nurse to audit the wander guard documentation on the Medication Administration Record (MAR)/Treatment Administration Record (TAR) weekly to ensure the monitoring and functioning of the wander guard for one month beginning on 04.29.2024, then monthly for 3 months ending on 7.29.2024. Maintenance will ensure the smoking closet doorknob is functioning appropriately through audits beginning weekly on 04/29/2024 for thirty days and then monthly for three months. The findings from these audits will be brought to our QAPI meeting on 05.16.2024 and then monthly for three months. The findings will be reviewed by the Interdisciplinary Team and the Quality Assurance(QA) committee which consists of which consists of the Administrator, Director of Nursing, Register Nurse Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director. The Quality Assurance (QA) Committee will make necessary recommendations as needed.	

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M 640	Continued From page 4 An interview, observation, and record review on 4/24/24 at 4:30 PM, with Licensed Practical Nurse (LPN) #7 confirmed that Resident #1 had a wander guard bracelet on his left wrist. She stated he had worn it for a long time. She stated that anyone that has a wander guard bracelet should have an order and then it will show on either the Electronic Medication Administration Record (EMAR) or Electronic Treatment Administration Record (ETAR) to monitor it every shift. A record review of the resident's physician's orders with LPN #7 confirmed that Resident #1 did not have an order for a wander guard, and it was not triggered on the residents EMAR or ETAR to check for functioning or placement of the wander guard bracelet each shift. An interview and record review on 4/24/24 at 4:40 PM, with LPN #3 confirmed that Resident #1's "wander guard" bracelet had not been monitored each shift to make sure it was still on the resident and functioning. An interview on 4/25/24 at 8:20 AM with the Director of Nurses (DON), revealed it was her expectation that Resident #1's physicians order would have been put in the resident's record and triggered for the staff to monitor the resident's wander guard placement and function. She stated the residents order for a wander guard dropped off in December 2023 after he returned from a hospital stay. She confirmed a residents wander guard needs to be monitored for placement and function to prevent an elopement. Record review of Resident #1's "Admission Record" revealed the resident was admitted to the facility on 4/12/18 with medical diagnoses that included Schizoaffective Disorder, Bipolar Type.	M 640		

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M 640	Continued From page 5 Smoking: An observation on 4/23/24 at 6:38 AM, revealed the smoking supply closet on the resident hall that held residents smoking supplies was unlocked. Observed a sign on the smoking supply closet door "Keep this door locked at all times". An interview and observation on 4/23/24 at 6:45 AM, with Housekeeping Staff #2 confirmed the smoking supply closet was unlocked and stated "they are supposed to keep that door locked at all times." Housekeeping Staff #2 stated the key is kept behind the nurse's desk. An interview and observation on 4/23/24 at 6:50 AM, with Licensed Practical Nurse (LPN) #6 confirmed that the resident smoking supply closet was unlocked, held resident's smoking supplies including at least one lighter and that it was supposed to always be locked for safety. An interview on 4/23/24 at 6:55 AM, with Registered Nurse (RN) #1 confirmed that the residents smoking supply closet was supposed to be locked at all times and the key is kept behind the nurse's station. She revealed that the purpose of keeping the smoking supply closet locked was to prevent residents from having access to the smoking supplies and the lighter. She stated "there is at least one lighter in there. If the residents got a hold of the supplies they'd be smoking in the rooms and we have oxygen in the building, so it's a safety issue." Record review of the "List of Resident on Designated Smoking list" undated, revealed there were 9 active smokers listed. An interview with Administrator on 4/25/24 at	M 640		

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M 640	Continued From page 6 11:00 AM, confirmed that the smoking supplies should always be locked up to prevent the residents from having access to the smoking supplies including the lighter for safety issues and that was the facilities policy.	M 640		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 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. 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. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, and facility	M1570	F-880-SS-D INFECTION PREVENTION & CONTROL 1. On 04/29/24, Licensed Practical	5/18/24

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M1570	Continued From page 7 policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by failing to utilize proper hand hygiene and maintaining a clean barrier for one (1) of five (5) care observations. Resident #13 Findings include: Review of the facility policy titled, "Infection Control Standard" with a revised date of 05-2023 revealed," STANDARD It is our standard to assume that patients are potentially infected or colonized with an organism that could be transmitted during the course of providing patient care services and therefore our facility applies the "Standard Precautions" infection control practices... 1. Hand Hygiene: a. During the delivery of patient care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces... e. Staff must perform hand hygiene (even if gloves are used): iii ...After contact with...nonintact skin, or wound dressing, visibly contaminated surfaces or after contact with objects in the resident's room... v... If hands shall be moving from a contaminated-body site to a clean-body site during resident care..." Observation of wound care treatment for Resident #13 on 4/23/24 at 2:45 PM revealed Licensed Practical Nurse (LPN) #4 washed her hands applied clean gloves and assisted Certified Nurse Aide (CNA) #2 with turning Resident #13 to her left side. LPN #4 began removing the resident's brief and then cleaned the wound to her right buttock with wound cleanser and then applied the wound treatment without changing out her gloves and washing her hands. When the	M1570	Nurse #4 completed an in-service with the Nurse Educator on wound care procedure and Infection Control Standard with emphasis on Hand Hygiene. 2. The Director of Nursing noted on 04.29.24 that 6 out of 42 residents with orders for wound care treatment had the potential to be affected by this allegation of deficient practice of not following infection control standard while providing wound care. 3. On 04/29/24, Licensed Practical Nurse #4 completed an in-service with the Nurse Educator on wound care procedure and Infection Control Standard with emphasis on Hand Hygiene. On 05.03.24, Nurse Educator provided in-service training on the infection control policy, specifically on Hand Hygiene, for 15 of 15 nursing staff. 4. The Director of Nursing will make rounds with License nurses to ensure compliance with wound care procedure weekly for 30 days beginning 04/29/2024 and then monthly for three months ending on 07/29/2024. The Director of Nursing will make rounds to ensure compliance with Hand Hygiene procedure weekly for 30 days beginning 04/29/2024 and then monthly for three months ending on 07/29/2024 The findings of this audit will be brought before the Quality Assurance (QA) committee monthly for three months beginning on 05/16/2024. The findings will be reviewed by the Interdisciplinary Team and the QA committee which consists of which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social	

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M1570	Continued From page 8 wound treatment to the right buttock was completed two unopened packages of abdominal (ABD) pads fell off the overbed table onto the floor, LPN #4 retrieved the unopened ABD packages off the floor while wearing her soiled gloves and placed the unopened ABD pads back on the clean barrier tray contaminating the clean barrier tray. LPN #4 then removed her gloves, washed her hands, and applied clean gloves. LPN #4 assisted CNA #2 with turning Resident #13 to her right-side, LPN #4 did not change her soiled gloves and proceeded to administer wound treatment to Resident #13's left outer thigh. An interview on 4/23/24 at 3:10 PM, LPN #4 confirmed she did not practice infection control measures by failing to change her gloves during wound treatment to both of the resident's wounds. She confirmed when she picked up the ABD packages from the floor while wearing her soiled gloves and laying them on the clean barrier that she contaminated her clean barrier. She confirmed that not practicing proper infection control measures could potentially cause an infection in the wound. During an interview on 4/23/24 at 3:45 PM, the Director of Nurses (DON) with LPN #4 present confirmed their policy regarding wound treatment is to make sure and change gloves and wash hands between soiled dressing and clean dressing care and confirmed by not doing so is an infection control issue and could delay healing. A record review of Resident #13's Admission Record revealed the resident was admitted to the facility on 6/12/2023 with diagnoses that included Pressure ulcer of right buttock and Type 2 Diabetes Mellitus with Hyperglycemia.	M1570	Service Director, Activity Director, and Medical Director.	