STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255138	A. BUILDING _____ B. WING _____	C 05/07/2025

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

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) MS # 28434 at the facility on 5/07/25. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated Activities of Daily Living (ADL) care, unnecessary medication regimen, facility staffing, and quality of care and cited F656 and F677. The census at the time of the survey was 60 and the facility is licensed for 60 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		6/13/25

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

Electronically Signed | 05/14/2025

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan for a resident requiring oral care for one (1) of three (3) sampled residents. Resident #3 Findings Include: Review of the facility policy titled "The Care Plan" with a revision date of 4/2019 revealed, "The Comprehensive Care Plan is completed within seven (7) days after the MDS (minimum data set) is completed ..."	F 656	Preparation and submission of this plan of correction by Ashland Healthcare and Rehabilitation, Ashland, MS does not constitute an admission agreement by the provider of the truth, or the facts alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is submitted and prepared solely pursuant to the requirements under the federal and state laws. F656 1. On 5/7/25 and by the Minimum Data	

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F 656	Continued From page 2 Record review of the Activities of Daily Living (ADL) "Care Plan" for Resident #3 revealed under, "Focus: The resident has an ADL self care performance deficit r/t (related to) Hemiplegia from hx (history) of CVA (Cerebrovascular Accident) affecting left side." Further review revealed the care plan was not developed for oral care. An observation of Resident #3 on 5/07/25 at 8:40 AM revealed she was sitting in her wheelchair in the hallway and was alert but confused and did not answer questions appropriately. Her lower lip was observed as dry and cracked with peeling skin. An observation of Resident #3 on 5/07/25 at 10:05 AM revealed she was lying in bed and her lower lip remained dry and cracked. An interview with Certified Nurse Aide (CNA) #1 on 5/07/25 at 10:35 AM revealed she did not perform oral care on Resident #3. She explained that the resident wore dentures, and she was able to wash them in the sink herself. An interview with Registered Nurse (RN) #1 on 5/07/25 at 10:58 AM confirmed Resident #3's lower lip was dry, irritated, and had peeling skin. An interview with the Administrator (ADM) on 5/07/25 at 12:20 PM confirmed the care plan was not developed for Resident #3 to have oral care and revealed that if it was not developed, the staff would not know to do it. An interview with the Minimum Data Set (MDS) Nurse on 5/07/25 at 12:48 PM revealed the purpose of the care plan was for the staff to know	F 656	Set Nurse, Resident #3 had a care plan revised to include oral care in Activities of Daily Living with staff assistance of. 2. 60 (sixty) residents out of a total census of 60 (sixty) had the potential to be affected due care plan not being specific to oral care. 3. On 5/7/25, an audit was completed by Director of Nurses and Assistant Director of Nurses and updates completed on all resident tasks showing where oral care was provided every shift. Minimum Data Set Nurse updated all resident care plans to be specific in Activities of Daily Living for oral care. On 5/7/25, Inservice was initiated by Director of Nurses and Nurses Educator on oral care being resident specific on each residents Activity of Daily Living care plan to Interdisciplinary Team and Nursing staff. 4. Audits will be conducted starting on 5/12/25, weekly for four (4) weeks, then monthly for three (3) months on all new admissions and re-admissions to ensure that all Activities of Daily Living Care Plans are resident specific to oral care and address the amount of assistance needed. The report on audit findings will be reviewed weekly and brought to the Quality Assurance Meeting for three (3) months, starting June 12, 2025. The Minimum Data Nurse will be responsible for monitoring and compliance.	

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F 656	Continued From page 3 what care to provide for the residents. She confirmed the care plan was not developed for Resident #3 related to oral care and stated, "We can't just assume the staff know to do it." Record review of the "Admission Record" revealed the facility admitted Resident #3 on 2/18/25 with medical diagnoses that included Nontraumatic Intracranial Hemorrhage in the Cortical Hemisphere, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant side, and Encounter for Attention to Gastrostomy. Record review of the "Brief Interview for Mental Status (BIMS) Evaluation" dated 5/6/25 revealed a summary score of 8, which indicated Resident #3 was moderately cognitively impaired.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide oral care for one (1) of three (3) residents requiring assistance with activities of daily living (ADLs). Resident #3 Findings Include: Review of the facility policy titled "Oral Care," with a revision date of 6/2022, revealed under "Standard: It is the standard of this facility that	F 677	F677 1. On 5/7/25, the Certified Nursing Assistant immediately performed mouth care on Resident #3. Registered Nurse Supervisor obtained an order for moisturizing lip balm to lips every shift and as needed on Resident #3 on 5/7/25. 2. Sixty (60) residents out of a total census of sixty (60) had the potential to be affected due to care plan and tasks not being specific on oral care.	6/13/25

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F 677	Continued From page 4 every resident will receive oral care at least twice daily, and as needed." Additionally revealed under "Process: ... 10. Inspect the resident's mouth, teeth and gums for open areas of irritation; notify the supervising nurse immediately of any problems noted or any complaints by the resident. 11. Apply lip balm to the resident's lips and use lemon and glycerin swabs to lubricate the resident's mouth ..." A telephone interview with a confidential source on 5/06/25 at 1:32 PM revealed Resident #3 was admitted to the facility after suffering a stroke and explained the resident had lost function of the left side of her body. The source revealed that the resident only received hydration through a feeding tube and reported the resident's lips were dry and cracked, and the skin was peeling to the point of bleeding. On 5/07/25 at 8:40 AM an observation of Resident #3 revealed she was sitting in her wheelchair in the hallway, that she was alert but confused and did not answer questions appropriately. Her lower lip was observed to be dry and cracked with peeling skin. On 5/07/25 at 10:05 AM an observation of Resident #3 revealed she was lying in bed and her lower lip remained dry and cracked with peeling skin. An interview with Licensed Practical Nurse (LPN) #1 on 5/07/25 at 10:17 AM revealed she was aware of Resident #3's dry lips and explained that she noticed it last week after a family member reported it. She stated, "It was dry and irritated and had started to bleed." She explained it was bleeding, but we thought the family member may	F 677	3. On 5/7/25, the Director of Nurses and Assistant Director of Nurses updated the task of Oral Care on all residents to provide the documentation on the certified nurses assistant plan of care of task completion. On 5/7/25, Inservice was initiated by Director of Nurses and Nurse Educator on oral care being resident specific on each residents Activity of Daily Living care plan and tasks were updated on all residents showing that oral care has been provided every shift and as needed according to certified nursing assistant documentation. 4. Audits will be conducted starting on 5/12/25, weekly for four (4) weeks, then monthly for three (3) months on five (5) residents to ensure oral care was documented on tasks and resident Activities of Daily Living are completed and the plan of care was followed. The Director of Nurses is responsible for monitoring and compliance. Beginning on 6/12/25, all findings on audits will be submitted to the Quality Assurance Performance Improvement for review and recommendation monthly for three (3) months.	

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F 677	Continued From page 5	F 677		

have wiped it and caused it to bleed. Furthermore, she revealed she notified the supervisor and knew that lip hydration was provided. LPN #1 confirmed she did not document this information in the notes and was unsure if anything was put into place for the issue.

Record review of the "Activities of Daily Living Task" for Resident #3 revealed there was no task set up for staff to complete oral care/hygiene and apply lip hydration.

On 5/07/25 at 10:35 AM an interview with Certified Nurse Aide (CNA) #1 revealed she did not perform oral care on Resident #3. She explained that the resident wore dentures, and she was able to wash them in the sink herself. CNA #1 confirmed she was aware of the resident's dry lips and revealed that she had not applied a moisturizer but explained that she did notify License Practical Nurse (LPN) #1 the previous weekend that her lips were dry and cracked.

On 5/07/25 at 10:58 AM an interview with Registered Nurse (RN) #1 revealed they had not initiated any treatment for Resident #3's lower lip and confirmed the lower lip was dry and peeling skin. She revealed that she tried to wash it with a warm wash cloth this morning, and it began bleeding. RN #1 confirmed the resident should have had oral care and a moisturizer applied to her lips and recognized this would be discomforting for the resident.

An interview with the Administrator (ADM) on 5/07/25 at 12:20 PM revealed she saw Resident #3's lips yesterday and stopped by the desk and

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F 677	Continued From page 6	F 677		

told the staff to do something about it. She confirmed the aide task was not set up to provide oral care, and verbalized it should have been. The ADM explained it was important to have proper oral care and lip moisturizer applied, especially when a resident was receiving nutrition through a feeding tube.

Record review of the "Admission Record" revealed the facility admitted Resident #3 on 2/18/25 with medical diagnoses that included Nontraumatic Intracranial Hemorrhage in the Cortical Hemisphere, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant side, and Encounter for Attention to Gastrostomy.

Record review of the "Brief Interview for Mental Status (BIMS) Evaluation" dated 5/6/25 revealed a summary score of 8, which indicated Resident #3 was moderately cognitively impaired.