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	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Health and Rehabilitation	16056 Boundry Drive Ashland, MS 38603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47874 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 . 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. (continued on next page)

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 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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 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 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.