STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255303	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briar Hill Rest Home	1201 Gunter Road Florence, MS 39073

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on interviews, record reviews, and facility policy reviews, the facility failed to implement/follow the care plan for three (3) of sixteen (16) sampled residents. Resident #12, Resident #13, Resident #48 Findings Include: A review of the facility policy titled Care Plans, updated 2/3/23 revealed, Policy: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care .Resident Care Summary-part of the Comprehensive Care Plan is used as the tool to make staff aware of the resident's daily care needs . Resident #12 A record review of the ADL (Activities of Daily Living) comprehensive Care Plan dated 1/29/24, revealed an intervention related to transfers as Transfers: Extensive Two Person Assist At 1:05 PM on August 13, 2024, as Certified Nursing Assistant (CNA) #2 recapped what she saw in the social media video, she specifically pointed out that she saw CNA #1 grab the resident under the arm and move her to the geriatric chair without assistance. She stated the transfer was unsafe because the resident should have been lifted by two people. On 8/14/24 at 9:28 AM, in an interview with Minimum Data Set (MDS) Nurse, she reviews and confirms with that the care plan for Resident #12 states that for transfers, the resident is an extensive two person assist. She said this intervention was put into place to ensure the safety of the resident. The MDS Nurse further added that care written and available on the kiosk (interactive computer terminal) of the wall in the hall of resident care areas, so that CNAs (Certified Nurse Aides) will know how to care for residents. Resident #13 (continued on next page)

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	A record review of Resident #13's comprehensive Care Plan dated 2/23/23 revealed At risk for Dyspnea/Shortness of Breath/Difficulty Breathing related to COPD and Respiratory Failure with Hypoxia . Interventions .Fluticasone Prop (Propionate) 50 mcg (micrograms) Spray, spray two (2) sprays in each nostril daily .Nasal Spray (sodium chloride), spray one (1) spray intranasally twice daily every day in each nostril . At 8:35 AM on 08/14/23, during an observation of medication administration with an observation and interview of medication administration with Licensed Practical Nurse (LPN) #2 reported and confirmed Fluticasone Propionate nasal spray and Saline nasal spray was out of stock. Therefore, Resident #13 was unable to receive the ordered medications. A record review of Resident #13's Admission Record revealed that the facility admitted the resident on 2/15/23, with diagnoses that included Chronic Obstructive Pulmonary Disease and Acute and Chronic Respiratory Failure with Hypoxia. A record review of Resident #13's Order Summary Report, with active orders as of 8/15/24, revealed a physician's order, with an order date of 4/2/24, for Nasal Spray (sodium chloride) 0.65% aerosol: one (1) spray in each nostril twice a day, every day, related to Chronic Respiratory Failure with Hypoxia and an order, with an order date of 2/15/23, for Fluticasone Propionate 50 MCG (microgram) Spray for two (2) sprays in each nostril daily, related to Chronic Obstructive Pulmonary Disease. Record review of the August 2024 Electronic Medication Administration Record (eMAR) documentation revealed Resident #13 had not received the Saline Nasal Spray at 9 PM on 8/13/24 and the 9 AM dose on 8/14/24. Fluticasone Propionate nasal spray was not documented as received at 8 AM on 8/14/24. Resident #48 A record review of Resident #48's comprehensive Care Plan dated 4/18/24 revealed Hypertension, controlled .Care Plan Goal . Reduce complications from Hypertensive symptoms .Bethanechol Chloride 25 mg tablet: Give 1 tablet via peg (Percutaneous Endoscopic Gastrostomy) tube before meals every day . On 8/14/24 at 2:46 PM, during an observation and interview with LPN #2 administering medications via PEG tube to Resident #48, his medications included Bethanechol Chloride. LPN #2 stated the Bethanechol Chloride was not available on her medication cart. The nurse checked her medication cart twice and checked the Omnicell (an automated medication dispensing cabinet) in the medication room, however, the medication was not available. Review of Resident #48's Admission Record revealed an admitted [DATE] with diagnosis of Essential (Primary) Hypertension and Chronic Systolic (Congestive) Heart Failure. Record review of Resident #48's Order Summary Report with active orders as of 8/15/24 revealed an order dated 4/19/24 for Bethanechol Chloride Tab 25 mg Give 1 tablet via PEG-tube three times a day related to Essential (primary) hypertension. A record review of Resident #48's August 2024 Electronic Medication Administration Record (eMAR) documentation revealed Bethanechol Chloride was documented as unavailable for two doses on 8/13/24 and the morning dose on 8/14/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1:52 PM, in an interview with Assistant Director of Nursing (ADON) stated they should reorder medications when it gets down to five (5) days left. She confirmed the residents' medications are listed on the care plans and the care plan is not followed if the medications are not given. On 08/14/24 at 4:03 PM, during an interview with the Director of Nurses (DON), she explained her expectations of nurses are to give medications per physician orders and follow care plans. She stated residents should receive medications as prescribed for their health conditions. 48669

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 47873 Based on observation, staff interview, and facility policy review, the facility failed to post the direct care daily staffing numbers in a location accessible to residents and visitors for two (2) of three (3) days of survey. Findings Include: Review of the facility ' s policy, Nurse Staffing Posting Information, revised 2/3/2023, revealed, .It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The nurse staffing information will be posted on a daily basis .2. The facility will post the nursing staffing data at the beginning of each shift . On 8/13/24 at 9:30 AM, there were no direct care daily staffing numbers posted in the facility. On 8/14/24 at 8:30 AM, there were no direct care daily staffing numbers posted in the facility. On 8/15/24 at 10:15 AM, in an interview with the Director of Nursing, she stated she was aware the nursing staffing had to posted in a prominent place that was readily accessible to residents and visitors at the beginning of the shift. On 8/13/24 at 2:45 PM, in an interview with Licensed Practical Nurse (LPN) #1, she revealed she was aware that staffing should be posted and stated that it was usually posted at the front desk. She stated that on Tuesday and Wednesday of this week there must have been a breakdown in communication since the staffing numbers did not get posted. On 08/15/24 at 10:34 AM, an interview with the Administrator revealed it was the policy of the facility to post the facility staffing information to ensure it was readily available in a manner that was readable by residents and visitors at any given time. The Administrator was unsure why the staffing information was not posted on the first and second day of the survey and he commented that it was normally posted at the nursing station for visitors and residents and that it was an important aspect of resident care and customer service.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41680 Based on observation, interview, record review, and facility policy review, the facility failed to ensure their medication error rate was less than five percent as evidenced by three (3) errors were observed out of twenty-six (26) medication administration opportunities. This affected two (2) of seven (7) residents observed during medication pass, resulting in a medication error rate of 11.54%. (Residents #48 and #13) Findings include: A review of the facility's policy titled, Medication Administration General Guidelines, (undated) revealed, Medications are to be administered as prescribed in accordance with good nursing principles and practices . Procedure .2. Medications are to be administered in accordance with the written orders of attending physicians, taking into consideration manufacturer's specifications, and professional standards of practice . A review of the facility's policy titled, Ordering and Receiving Medications from Pharmacy, (undated) revealed, Medications are ordered and received from the pharmacy in a timely manner .Procedure . 2. A. Re-order medication in advance of need to ensure an adequate supply is on hand . Resident #48 On 8/13/24 at 2:46 PM, during an observation with Licensed Practical Nurse (LPN) #2 as she administered medications to Resident #48 via PEG(Percutaneous Endoscopic Gastrostomy) tube, it was noted the medications due at that time were Gabapentin 400 milligrams (mg) capsule (three times a day) and Bethanechol Chloride 25 mg tablet (three times a day) via PEG tube. LPN #2 stated that the Bethanechol Chloride was not in the medication cart. The nurse checked her cart twice and checked the Omnicell (an automated medication dispensing cabinet) in the medication room, but the medication was unavailable. Record review of Resident #48's Order Summary Report with active orders as of 8/15/24 revealed an order dated 4/19/24 for Bethanechol Chloride Tab 25 mg Give 1 tablet via PEG-tube three times a day related to Essential (primary) hypertension. A record review of Resident #48's Admission Record revealed that the facility admitted the resident on 4/2/24, with diagnoses that included Essential Hypertension and Chronic Systolic Heart Failure. A record review of Resident #48's August 2024 Electronic Medication Administration Record (eMAR) documentation revealed Bethanechol Chloride was documented as unavailable for two doses on 8/13/24 and the morning dose on 8/14/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 9:07 AM, during an interview, LPN #2 stated it was the responsibility of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the cart nurses to ensure that medications were available for residents. She stated that if a resident was out of medications, the nurses must report it. She usually ordered medications when she noticed the supply was down to five (5) days. She emphasized the importance of residents receiving medications as ordered by the physician. She also stated that she usually ordered medications stat (meaning that the pharmacy was to deliver them the same day), but admitted she forgot to order Resident #48's blood pressure medication stat, which should have been done. Resident #13 At 8:35 AM on 08/14/23, during medication administration an observation and interview with Licensed Practical Nurse (LPN) #2 revealed that (LPN) #2 reported and confirmed Fluticasone Propionate nasal spray and Saline nasal spray was out of stock. Therefore, Resident #13 was unable to receive the ordered medications. On 8/14/24 at 9:05 AM, during an observation of Resident #13 receiving his inhaler medication, the resident asked LPN #2 if they had found his nasal spray. The nurse stated, No, and the resident commented that the last time he had received it was yesterday. A record review of Resident #13's Admission Record revealed that the facility admitted the resident on 2/15/23, with diagnoses that included Chronic Obstructive Pulmonary Disease and Acute and Chronic Respiratory Failure with Hypoxia. A record review of Resident #13's Order Summary Report, with active orders as of 8/15/24, revealed a physician's order, with an order date of 4/2/24, for Nasal Spray (sodium chloride) 0.65% aerosol: one (1) spray in each nostril twice a day, every day, related to Chronic Respiratory Failure with Hypoxia and an order, with an order date of 2/15/23, for Fluticasone Propionate 50 MCG (microgram) Spray for two (2) sprays in each nostril daily, related to Chronic Obstructive Pulmonary Disease. Record review of the August 2024 eMAR documentation revealed Resident #13 had not received the Saline Nasal Spray at 9 PM on 8/13/24 and the 9 AM dose on 8/14/24. Fluticasone Propionate nasal spray was not documented as received at 8 AM on 8/14/24. A record review of Resident #13's eMAR revealed that this was the second (2nd) dose of saline nasal spray and first (1st) dose of Fluticasone Propionate nasal spray that the resident had missed. On 8/14/24 at 1:52 PM, during an interview with the ADON, it was confirmed that medications should be reordered when the supply reached five (5) days. On 8/14/24 at 2:56 PM, in a phone interview, LPN #2 confirmed that she did not administer Resident #48's Bethanechol Chloride medication the previous day. However, she also added that she had spoken to the NP (Nurse Practitioner) and the NP clarified the order was for urine retention and not blood pressure. She stated she informed the Administrator, DON, and ADON about Resident #48's medication and Resident #13's medications being out of stock. She mentioned that she was unaware of the backup pharmacy and had charted it as a 9 on the eMAR because the medication was not in stock. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 4:03 PM, during an interview with the DON, it was confirmed that cart nurses were responsible for informing her and the ADON when medications were out of stock. The DON stated that cart nurses should ensure that medications are in stock for residents to receive their medications as scheduled. She expressed uncertainty about why the nurses ran out of medications but confirmed that nurses were supposed to order medications when the supply was down to a five-day supply to avoid running out. She also stated that nurses were expected to follow physician orders. The DON mentioned she was unaware of a backup pharmacy but stated that medications should arrive the day they are ordered unless they are special-order medications. She emphasized that the out-of-stock medications were not special-order medications and reiterated her expectation that nurses administer medications per physician orders, as not receiving medications as prescribed could harm residents due to their health conditions.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47873 Based on observation, interviews, record review, and facility policy review, the facility failed to serve therapeutic portion sizes of foods as planned per the facility's menu for one (1) of seven (7) food items requiring specific portions on the lunch meal tray line. Resident #40 Findings Include: A review of the facility's policy, Tray Assembly, revised 6/17, revealed, .Prepared foods are portioned and assembled for individual meals in the food and nutrition services department. Procedure .6. Menu items and equipment are positioned in reach of the food service employees. These items include .c. Serving utensils as specified on the menu and equipment needed for correct portions .10. Portions are .weighed on portion scales . A record review of the facility's Menu Guide Report for Spring/Summer 2024 revealed the following portion sizes to be served at lunch: 3 ounces of country meatloaf, 1/3 cup of mashed potatoes,1-ounce brown gravy, 1/3 cup of buttered green peas, one (1) fresh baked roll, one (1) piece of confetti cake with icing, and one (1) cup of iced tea. On 08/13/24 at 10:51 AM, during an interview, Resident #40 complained her meals had inconsistent portion sizes and stated she had mentioned this concern to the facility staff. On 08/13/24 at 12:35 PM, an observation of two (2) sampled meal trays with the Certified Dietary Manager (CDM) revealed the meal consisted of meatloaf, mashed potatoes, green peas, roll, cake and tea. The portion sizes for the meatloaf were notably different. On 08/13/24 at 12:50 PM, during an interview, Dietary Staff #1 acknowledged that she sliced the meatloaf freehand, resulting in each slice being visibly different in size. The cook confirmed that a serving of meatloaf should be 3 ounces and reported that the facility had not provided any means for her to measure a serving of meatloaf. On 08/13/24 at 1:00 PM, during an interview with the Certified Dietary Manager (CDM), he stated that he was unaware the meatloaf was not evenly sliced. The CDM confirmed that a serving of meatloaf should be 3 ounces and reported that the facility had a scale available to measure portions of meatloaf. However, he confirmed that no scale was present during the serving of that day's meatloaf. On 08/15/24 at 10:34 AM, during an interview with the Administrator, it was confirmed that he had already been made aware of the inconsistent portions of food served during lunch on 08/13/24. The Administrator stated that he expected the dietary staff to follow the portion sizes identified on the menu. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/01/2024 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Care Profile revealed a physician order that Resident #40 was to receive a Regular diet, Regular texture, and Large portions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on observation, interviews, and facility policy review, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to unlabeled foods, foods without identified dates, exposed foods, and overly ripe produce for one (1) of two (2) kitchen observations. Findings Include: A review of the facility's policy, Storage of Refrigerated Food, revised ,d+[DATE], revealed, The facility ensures the quality and safety and sanitation of refrigerated foods through accepted storage practices. Procedure .4. No food is left uncovered. 5. All opened foods are labeled with common name of food, date stored, and use-by date . On [DATE] at 9:19 AM, during an observation of the kitchen and interview with the Certified Dietary Manager (CDM), Refrigerator #1 had nine (9) overly ripe tomatoes containing white biological growth on each tomato. There was (1) unopened bag of salad mix with a facility received sticker of [DATE], with no manufacturer's date, and a brown discolored liquid inside the bag. There was (1) opened block of cream cheese inside a plastic food storage bag with a written-on date of [DATE]. The CDM explained that this was the date it came in and most likely the date it was opened. Additionally, there was (1) plastic storage bag of sliced ham with a handwritten date of ,d+[DATE], (1) plastic storage bag of bologna dated [DATE], (1) plastic storage bag of bologna with a date of [DATE], and (1) plastic storage bag of bologna dated [DATE]. The CDM stated these were the dates the sliced ham and bologna were opened and placed in the bags. An observation of Refrigerator #3 revealed four (4) eight (8) ounce containers of chocolate milk wrapped in plastic wrap with a manufacturer's date of [DATE] and a received-on date of ,d+[DATE]. An observation of the freezer revealed (1) bag of shrimp that was opened, and the shrimp was exposed. On [DATE] at 01:00 PM, during an interview, the CDM acknowledged the overly ripe produce, outdated milk, and unlabeled food items in the kitchen. The CDM stated it was his responsibility to check for outdated foods and to insure proper labeling. He expressed that food should be checked daily and confirmed that he in-serviced the staff monthly on food safety. On [DATE] at 12:20 PM, an interview with the Administrator revealed he was aware of the findings during the kitchen observations regarding unlabeled and out of date food items, as well as expired and exposed foods. The Administrator stated he expected the kitchen staff to monitor the foods daily for expired items and to inspect the produce daily.