STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445333	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Community Living Center	41 Hospital Drive Lexington, TN 38351

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility investigation review, medical record review, and interview, the facility failed to report a staff to resident allegation of verbal abuse for 2 of 2 (Resident #1 and #13) resident abuse allegations reviewed within the required timeframe. The findings included: 1. Review of the facility policy titled, Investigating Grievances and Concerns, dated 11/23/2016, revealed, .All reports of abuse, neglect, mistreatment, or misappropriation of property must be reported to the administrator within twenty-four (24) hours of their occurrence . 2. Review of the Facility Reported Investigation dated 1/2/2025, revealed an allegation of verbal abuse when Licensed Practical Nurse (LPN) F allegedly yelled at Resident #1 and #13. The alleged incident occurred on 12/28/2024. A call to the Director of Nursing (DON) was made by Registered Nurse (RN) G on 12/31/2024. The DON returned the call on 1/2/2025. The Administrator was notified, and the report was filed with the State agency on 1/2/2025, 5 days after the alleged incident. 3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Hypertension, Dementia, and Anxiety Disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #1 had severe cognitive impairment. 4. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Delusional Disorder, and Hypertension. Review of the annual MDS dated [DATE], revealed a BIMS score of 9, which indicated Resident #13 had moderate cognitive impairment. During a telephone interview on 5/29/2025 at 6:51 PM, RN G was asked to recall an event of alleged verbal abuse between LPN F and Residents #1 and #13. RN G stated these 2 patients were arguing with each other when LPN F went into the room and started to yell and curse, saying, .'Oh hell, we are not doing this today' . RN G felt this was inappropriate and concerning and stated she called the DON immediately. When asked what time she notified the DON, RN G stated she could not remember exactly what time, but it was on the 3:00 to 11: PM shift toward the end of the shift. RN G was asked if LPN F worked the rest of the shift. She stated, .I believe she did . During a telephone interview on 5/30/2025 at 11:04 AM, the DON was asked about the alleged verbal abuse with LPN F and two sisters who reside at the facility. The DON stated RN G attempted to call on 12/31/2024. The DON was unable to answer the call and RN G left a message stating she needed to speak with her about LPN F. The DON returned the call on 1/2/2025, and after hearing about the allegation, reported it to the Administrator. The DON verified any allegation of abuse must be reported to the proper agency within 2 hours and within 24 hours, if no bodily harm occurred. During an interview on 5/30/2025 at 11:13 AM, the Administrator stated she was the Abuse Coordinator, and the DON was her backup Abuse Coordinator. Staff were educated on abuse upon hire, monthly, with any abuse allegation, and annually. She stated she was responsible to report abuse allegations to the state agency within 2 hours. When asked to recall the event that involved the allegation of verbal abuse, the Administrator stated the allegation occurred on 12/28/2024. RN G tried to contact the DON on 12/31/2024 but was unsuccessful. A message was left for the DON requesting a return call. The DON returned the call on 1/2/2025. The Administrator stated RN G had never worked in a nursing home before and may not have known to report the incident immediately.

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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. Based on policy review, observation, and interview, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions, when large quantities of gray dust were found on overhead pipes, chains supporting the vent hood, and air conditioner/return vents; when plastic containers holding dry food items had dried substances and loose particles on top of the lids; when stainless steel tables, metal storage racks, and the steam table, were found with a brown substance that has the appearance of rust on the legs; and when the steam table had a black substance build up at the base of the legs; when a running streak of dried brown substance was found on the outside of the vent hood; when a discolored paper was found stuck underneath the rim of the vent hood; when white flakey and dark brown particles were found on the lower shelf of the milk cooler; and when a large round brown dried stain was found on the shelf paper in the cabinet where the plastic drinking glasses were stored. The facility had a census of 33 with 33 of those residents receiving a tray from the kitchen.The findings include:1. Review of the facility policy titled, Cleaning Schedule, with a revision date of 8/31/2018, revealed The Food and Nutrition Services staff shall maintain the sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professional .The department responsible for maintaining the cleanliness of the satellite kitchen is up to the discretion of the Community . 2. Observation in the kitchen on 5/27/2025 at 9:05 AM, revealed the following: a. gray dust on the overhead pipes, chains supporting vent hood, and air conditioner/return vents. b. large plastic containers holding dry food items had dried substances and loose particles on top of lids. c. a dark brown substance that has the appearance of rust on the legs of a stainless-steel table, the metal storage rack near the hand sink, and the steam table. d. a black substance build-up on the base of the legs of the steam table. e. a dried brown substance running down the outside of the vent hood. f. discolored paper underneath the rim of the vent hood. g. a large, round, brown dried stain on the shelf paper in the cabinet where the plastic drinking glasses were stored. Observation in the employee break room in the milk cooler on 5/27/2025 at 10:20 AM, revealed a white flakey dried substance and brown dried substance on the lower shelf inside the milk cooler. During an observation and interview in the kitchen on 5/28/25 at 3:52 PM, the Certified Dietary Manager (CDM) was asked should dust particles be on the air conditioner vent. The CDM stated, No . The CDM confirmed that the return vent over the 2-compartment sink should not have dust particles on it. The CDM confirmed that the metal racks and stainless- steel tables should not have rust on them. The CDM was shown the round dark brown stain on the shelf liner in the cabinet where the glasses were stored and confirmed the stain should not be there. The CDM was shown the white and brown dried flakey particles on the bottom shelf of the milk cooler in the employee break room and confirmed it was probably dried milk dripping from the containers on the upper shelf and it should not be there.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 5 of 12 (Residents #14, #17, #22, #28, and #29) residents when 3 (Housekeeper B, Certified Nursing Assistant (CNA) E, and Licensed Practical Nurse (LPN) A) staff members failed to change mop water and mop head after cleaning an isolation room and failed to clean resident reusable equipment before use. The findings included: 1. Review of the facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment revised September 2022, revealed, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard .Reusable items are cleaned and disinfected or sterilized between residents .Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions .Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident . 2. Review of the facility policy titled, Cleaning and Disinfecting Residents' Rooms, dated August 2013, revealed The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms .Change mop solution water at least every three (3) rooms, or as necessary . When possible, isolation rooms should be cleaned last and water discarded after cleaning rooms . 3. Review of the undated facility policy titled, Mops, revealed Clean mop heads must be applied when changing areas of mopping and when used in isolation rooms. 4. Review of the medical record revealed Resident #17 was admitted to the facility with diagnoses including Hypertensive Heart Disease, Heart Failure, Hypertension, Diabetes, Neuropathy, Pseudomonas, and Pressure Ulcer Left Heel Stage 4. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed Resident #17 has a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact, diagnoses of Multi-Drug-Resistant Organism (MDRO), Stage 4 Pressure Ulcer, and an infection of the foot with an application of a dressing. Review of the Care Plan dated 3/17/2025, revealed .I [Resident #17] am in Contact isolation r/t [related to] Pseudomonas [a bacteria that can cause an infection on the skin and in open wounds] to bilateral heel wounds .Contact isolation precautions r/t MRSA [Methicillin-Resistant Staphylococcus Aureus, an infection resistant to many different antibiotics] to bilateral heel wounds .contact isolation .PPE [Personal Protective Equipment] on door .wound to her bilateral heels . Review of the facility Order Summary Report for Resident #17 revealed, .Contact Isolation precautions for pseudomonas R [right] heel .4/23/2025 . During an interview on 5/27/2025 at 10:18 AM, Housekeeper B confirmed Resident #17 was in isolation. Housekeeper B was asked what the process was when mopping a contact isolation room. Housekeeper B stated, We use a string mop [a mop head that can be reused] .we have an all-purpose cleaner that we put in our mop water . Housekeeper B confirmed she only changes her mop water twice a day and doesn't change it after mopping a contact isolation room. Housekeeper B was asked do you use the same mop and mop water in a non-isolation room after mopping an isolation room. Housekeeper B stated, Yes .we should be using the ones (disposable mop heads) that we throw away, but we don't . Housekeeper B confirmed she doesn't change the water unless it was visibly soiled. Housekeeper B was asked if bleach or any other cleaning agent was added to the water to clean an isolation room that kills things like HIV, C-Difficile, COVID, or any infectious diseases Housekeeper B stated, No . During observation and interview on the back hall on 5/27/25 at 10:40 AM, Housekeeper B exited Resident #17's room and entered Resident #22 and #28's room. Housekeeper B was asked did you change your mop water and the mop head prior to entering (named Resident #22 and #28's room). Housekeeper B stated, No. Housekeeper B was asked how many rooms you cleaned using the same mop water and mop head that was used in Resident #17's room. Housekeeper B stated, Three. During an interview on 5/27/2025 at 11:00 AM, the Maintenance/Environmental Services (EVS) Supervisor confirmed staff should be using bleach to clean rooms of residents who are in isolation. The Maintenance/EVS Supervisor confirmed that the mop water and mop head should be changed immediately after cleaning an isolation room and it should never be used in a non-isolation room once it has been used. During an interview on 5/28/25 at 9:59 AM, the Director of Nursing (DON) confirmed that isolation rooms should be cleaned at the end of the day and staff should change the mop head and mop water before using in another resident's room. 5. Review of the medical record revealed Resident #14 was admitted to the facility with diagnoses including Dementia, Bipolar Disorder, and Delusional Disorder. Review of the quarterly

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a safe, sanitary, and comfortable environment for 2 of 5 (Resident #8, #12, #20, #24, #26, and #337) resident shared bathrooms observed. The findings include: 1. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating Resident #12 was severely cognitive impaired, and was dependent on staff for Activities of Daily Living skills (ADLs). 2. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Anxiety, and Difficulty Walking. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, indicating Resident #24 was cognitively intact, and required staff set up for ADLs. 3. Review of the medical record revealed Resident #337 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Vascular Implant, Thrombocytopenia, and Dissection of Artery. The MDS was incomplete and unavailable due to the projected completion date of 5/29/2025. Observation in the resident shared bathroom for Residents #12, #24 and #337 on 5/27/2025 at 9:50 AM, 11:48 AM, and 12:01 PM, revealed the following: a.1 bottle of Listerine mouthwash sitting on the paper towel dispenser, unlabeled and uncontained b. 1 clear plastic glass sitting on top of the vanity, unlabeled and uncontained c. 1 toilet plunger uncovered sitting on the floor beside the toilet, uncontained d. 1 packet of Wet One wipes on top of the toilet paper dispenser, unlabeled and uncontained e. 1 gray wash basin sitting on the floor underneath the sink, unlabeled and uncontained. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 5/27/25 at 12:01 PM, Licensed Practical Nurse (LPN) A confirmed the bathroom was a resident shared bathroom with Resident #12, #24, and #337. LPN A was shown the Listerine Mouthwash on top of the paper towel dispenser, unlabeled and uncontained, the Wet One wipes on top of the toilet paper dispenser, unlabeled and uncontained, the toilet plunger on the floor next to the toilet uncovered, one clear plastic drinking glass on top of the sink, and the gray wash basin underneath the sink, unlabeled and uncontained, and was asked how should these items be stored. LPN A confirmed that a resident's personal items should be put in the resident's drawer and should be labeled with their names on it, the plastic drinking glass should be taken to the kitchen to be cleaned and not be in the resident's bathroom, the mouthwash should be labeled with the resident's name and placed in the resident's drawer by their bed, and the gray wash basin should be wrapped in plastic and placed in the resident's drawer by their bed. 4. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus, Neuropathy, Abnormalities of Gait and Mobility, and Bipolar Disorder. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, indicating Resident #8 had no cognitive impairment, and required substantial/maximal assistance to total staff dependence for ADLs. 5. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Bipolar Disorder and Chronic Pain Syndrome. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, indicating Resident #20 had no cognitive impairment, and was dependent on staff for ADLs. 6. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Cerebral Infarction, and Hypertension. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 10, indicating Resident #26 had moderate cognitive impairment, and required partial/moderate staff assistance for ADLs. Observations on the back hall in the shared bathroom for Resident # #8, #20,and #26 on 5/27/2025 at 9:30 AM and 11:25 AM, revealed 1 bedpan with a urinal inside it on the back of the toilet and 1 bedpan with a bath basin inside it on the bathroom floor next to the sink, unlabeled and uncontained. During an interview on 5/27/2025 at 3:15 PM, LPN A confirmed the bedpans, urinal, and bath basin should have been labeled.