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 _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR HILL REST HOME	1201 GUNTER ROAD FLORENCE, MS 39073

(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 ***Amended 2567 to correct tag F-623 scope and severity level from "F" to "E".*** The State Agency (SA) conducted an annual survey from 8/26/19 through 8/29/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F623, F656, F690, F693, F758, and F803. The facility was licensed for 60 beds, and had a census of 58 at the time of survey	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		10/1/19

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

Electronically Signed | 09/26/2019

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F 623	Continued From page 1 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623		

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to notify the Resident Representative of a transfer in writing to a hospital for (4) of four (4) residents reviewed for hospitalization Residents #8, #35, #17, and #44.	F 623	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #8, #35, #17 and #44 had The	

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F 623	Continued From page 3 Findings include: A review of the facility's policy titled, "Transfer and Discharge", dated 5/03/18, revealed for Emergency Transfers/Discharges, "the facility will provide notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours. The facility will provide transfer notice as soon as practicable to resident and representatives". According to the Policy and Procedure, "Transfer and or Discharge (Including AMA-Against Medical Advice), the policy revealed: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered. Definitions: "Transfer and discharge" included movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not. "Transfer" refers to the movement of a resident from a bed in once certified facility to a bed in another certified facility when the resident expects to return to the original facility. Resident #44 Review of Resident #44's, "Transfer Summary", dated 8/3/19 at 12:37 AM, revealed the resident was transferred to the hospital for Hypotension and Dizziness. Review of Resident #44's medical record revealed a Bed Hold Form was signed by the resident. The facility was not able to provide, and/or find a	F 623	Transfer/Discharge letter and Bed Hold Form signed by the resident but did not have The Transfer/Discharge letter and Bed Hold Form signed by the Resident Representative. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program concerning The Transfer/Discharge letter and Bed Hold Form was completed on August 30, 2019 for the Social Service Director and Business Office Manager by the Director of Nursing. An in-service education program concerning The Transfer/Discharge letter and Bed Hold Form was began on August 30, 2019 by the Social Service Director for Registered Nurses and License Practical Nurses. An in-service education program was done on September 20, 2019 by the Director of Nursing concerning The Transfer/Discharge letter and Bed Hold Form for Registered Nurses and Licensed Practical Nurse.	

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F 623	Continued From page 4 written transfer notification to the resident or her representative. On 8/28/19 at 9:32 AM, an interview with the Director of Nurses (DON), revealed the facility notified the family verbally over the phone when they were transferred from the facility. Review of the Departmental Note, dated 8/3/19 at 3:08 AM, revealed the nurse called and left a message for Resident #44's son about the transfer. Resident #17 Review of Resident #17's Physician's Order List, dated 6/18/19, revealed an order to refer Resident #17 to a Geri Psych Unit for evaluation and treatment of behaviors. Review a document provided by the facility titled, "Notice of Resident Transfer or Discharge", revealed the document was signed by Resident #17, but there was no Transfer/Discharge letter or Bed Hold notice sent to the Resident Representative regarding a transfer to the hospital on 5/06/19. An interview, on 8/28/19 at 9:33 AM, with Resident #17 revealed when he was asked if he knew why he was sent to the hospital on 5/6/19, Resident #17 smiled and said "your hands are cold. Resident could not answer the question. An interview, on 8/29/19 at 11:02 AM, with Social Services Director revealed, "The Transfer/Discharge letter nor the Bed Hold notice was not sent out to the Resident Representative".	F 623	4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrative Assistant or Business Office Manager will complete a daily census on residents transferred/discharged from the facility. The daily census will be discussed in department head morning meeting. The Social Service Director will produce a copy of The Transfer/Discharge letter and Bed Hold Form during the department head morning meeting. If unable to obtain signatures from a Resident Representative a certified return receipt letter will be mailed out the same day. The Social Service Director or Business Office Manager will complete a check off form daily to confirm The Transfer/Discharge and Bed Hold Form is complete. Findings of the check off form validating the complete Transfer/Discharge and Bed Hold Form will be discussed monthly with the Administrator. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been met.	

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F 623	Continued From page 5 An interview, on 8/29/19 at 11:03 AM, with the Director of Nursing (DON) revealed, "The Transfer/Discharge letter and Bed Hold notice should have been mailed to the Resident Representative and it was not". Resident #35 Review of Resident #35's medical record revealed the resident was sent to the hospital on 7/27/19, and the facility failed to produce a Transfer/Discharge letter or Bed Hold notice that was mailed to the Resident Representative. Review of Resident #35's Physician Telephone Order, 7/27/19, revealed an order to "transfer Resident #35 to the Emergency Room for Evaluation/Tachycardia. An interview, on 8/29/19 at 11:02 AM, with the Social Services Director revealed, "The Transfer/Discharge letter nor the bed hold notice was sent out to the Resident's Representative". An interview, on 08/29/19 at 11:03 AM, with the Director of Nursing (DON) revealed, "The Transfer/Discharge and bed hold notice letter should have been mailed to the family and it was not". Resident # 8. In an Interview, on 8/26/19 at 10:42 AM, Resident # 8 revealed he was recently discharged from the hospital. Review of Resident # 8's Physician Telephone Orders revealed an order dated 8/07/2019 at 10:05 PM, to send the resident (Name of	F 623		

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F 623	Continued From page 6 Hospital) for further evaluation. The physician orders revealed Resident # 8 returned to the facility on 8/13/2019. Review on Resident #8's Departmental Notes, dated 8/7/19 at 10:26 PM, revealed, "Resident did not eat dinner and had very little urine output in drainage (bag) and very dark in color. (Name of Physician) called and stated to send resident to (Name of Hospital) for further evaluation. Resident Responsible Party (RP) his wife notified and notified of new order. (Name of Ambulance Service) notified and arrived in building at 10:34 PM to transport resident to hospital." Review of the Minimum Data Set (MDS), revealed Resident #8 was admitted to an Acute Hospital, and returned to the facility on 8/12/19. On 8/29/2019 at 12:15 PM, an interview conducted with the Director of Nursing (DON), revealed the facility did not mail the notification of transfer to the Responsible Party (RP).	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		10/1/19

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F 656	Continued From page 7 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to implement Resident #33's Care Plan related to incontinent care, and Resident #38's Care Plan related to Percutaneous Endoscopic Gastrostomy (PEG) tube site care. This concern was identified for two (2) of 23 resident care plans reviewed.	F 656	1. Immediate action(s) taken for the resident(s) found to have been affected include: Certified Nursing Assistant (CNA #1) failed to follow the care plan concerning infection control practices to include hand washing and proper use of gloves while providing incontinent care and perineal care. In-service and competency skill	

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F 656	Continued From page 8 Findings include: A review of the facility's policy titled, "Care Plans", with a revision date of 3/28/18, revealed each resident will have a person centered plan of care to identify problems and identify how the team will provide care. A review of Resident #33's Comprehensive Care Plan revealed the resident had a concern, dated 12/19/18, with bowel and bladder incontinence, and needed assist with perineal cleansing as needed. An observation, on 8/26/19 at 9:18 AM, revealed a strong urine smell in Resident #33's room. An observation, on 8/28/19 at 4:51 PM, revealed with Certified Nursing Assistant (CNA) provided Resident #33's perineal care. CNA #1 used peri-wipes and wiped front to back once and threw the wipe away. CNA #1 turned the resident over and wiped over the buttocks and sacrum without changing gloves. CNA #1 then removed her gloves and put on a new pair of gloves without performing hand hygiene. CNA #1 applied a on Resident #33, repositioned the resident in the bed. CNA #1 removed her gloves and performed hand hygiene. An interview, on 8/28/19 at 4:53 PM, with CNA #1 revealed she had just been hired two weeks ago and had completed a competency skills check off during orientation that included perineal care. CNA #1 said the policy of the facility was to wash hands between going from dirty to clean, and she should have washed her hands. CNA #1 said the concern was cross contamination.	F 656	check off for hand washing techniques and incontinent care was performed by Certified Nursing Assistant (CNA#1) and evaluated by the Staff Development Nurse on August 30, 2019 to ensure the care plan was followed. Registered Nurse (RN#1) failed to follow the care plan concerning infection control practices to include glove usage and hand hygiene during stoma site care. In-service and competency skill check off for glove usage, hand hygiene, and stoma site care was performed by Director of Nursing on August 30, 2019 for Registered Nurse (RN#1) to ensure the care plan was followed. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that require incontinent care and perineal care have the potential to be affected. The facility has determined that residents that need stoma site care have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program on following the care plan concerning infection control practices to include hand washing, proper use of gloves while providing incontinent care and perineal care was began on August 30, 2019 by the Staff Development Nurse for the	

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F 656	Continued From page 9 An interview, on 8/29/19 at 9:52 AM, with Licensed Practical Nurse (LPN) #2/MDS nurse, revealed the expectation with the care plan was for the staff to follow the care plan and to follow the facility policies for peri care. An interview, on 8/28/19 at 5:30 PM, with the Director of Nursing (DON) revealed the policy of the facility was to perform the hand hygiene between dirty and clean to prevent the possible spread of infection. A review of Resident #33's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/15/19, revealed the resident was always incontinent. Resident #38 Review of Resident #38's Care Plan, revealed the concern, Inadequate nutritional intake; PEG tube for supplemental nutrition, dated 3/7/19. The Interventions included clean gastrostomy and periostomal area with normal saline. Pat dry. Cover with a clean drain sponge and secure with tape. Change every day (QD), and as needed (PRN) if dressing becomes soiled, wet or dislodged. An observation, on 08/28/19 at 2:25 PM, revealed Registered Nurse (RN) #1 entered Resident #38's room to provide Enteral Feeding Care and stoma (site) care. RN #1 put gloves on as she was standing in the hall at the wound care cart. RN #1 wiped the tray with Sani-cloth bleach wipes. RN #1 removed her gloves and entered Resident #38's room. Licensed Practical Nurse (LPN) #1 entered the room to assist RN #1 in positioning the resident. RN #1 placed a red bag	F 656	Certified Nursing Assistants (CNA s). Competency skills check off s for hand washing techniques and incontinent care and perineal care by the Director of Nursing or Staff Development Nurse began on August 30, 2019 with the Certified Nursing Assistants (CNA s). An in-service education program was done on September 20, 2019 by the Director of Nursing and Staff Development Nurse for nursing staff to include following the care plan concerning infection control practices to include hand washing techniques, proper use of gloves while providing incontinent care and perineal care. An in-service education program on following the care plan concerning infection control relating to glove usage, hand hygiene and stoma site care was began on August 30, 2019 by the Director of Nursing with Registered Nurses and License Practical Nurses. Competency skills check off s for glove usage, hand hygiene and stoma site care by the Director of Nursing and Staff Development began on August 30, 2019 with Registered Nurses and License Practical Nurses. An in-service education program was done on September 20, 2019 by the Director of Nursing concerning infection control to include following the care plan concerning glove usage, hand hygiene	

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F 656	Continued From page 10 inside the garbage can by the Resident #38's bed. RN #1 placed a paper towel on the over bed table and placed the tray containing the supplies on the paper towel. RN #1 washed her hands and dried her hands with a paper towel and then used the same paper towel to turn the faucet off. RN #1 pulled the divider curtains between Resident #38's bed and her roommate's bed. RN #1 gloved and stated, "I should have washed my hands again after touching the curtains and gloving". RN #1 kept the gloves on and continued to provide care. RN #1 removed the soiled dressing from around the PEG tube stoma and placed it in the red biohazard bag. RN #1 removed her gloves, washed her hands and dried them with a paper towel and then used the same paper towel to turn the faucet off. RN #1 gloved, opened a pack of gauze, and took the gauze from the packet holding the gauze in her gloved hand. RN #1 poured normal saline onto the gauze she was holding in her hand. RN #1 took the gauze and wiped around the stoma, holding the tubing in the left hand, in a dabbing motion from one side of the stoma to the other side. RN #1 turned the gauze over and continued to wipe the stoma again. RN #1 took the gauze and rubbed an area on each side of the stoma trying to get dried exudate removed from the skin using the same gauze. RN #1 discarded the gauze in the red biohazard bag. RN #1 opened another pack of gauze, holding it in her gloved hand, and poured normal saline onto the gauze. RN #1 wiped the tubing in a circular motion, using the same spot on the gauze, around the tubing from the point of entry into the stoma continuing all the way up the tubing. RN #1 removed her gloves, washed her hands, dried her hands with a paper towel and used the same paper towel to turn the faucet off. RN #1 gloved, opened a sponge gauze and	F 656	and stoma site care for nursing staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services or Registered Nurse or Staff Development Nurse will complete a random competency skills check off of hand washing techniques and incontinent care weekly with three (3) Certified Nursing Assistant (CNA)s for four (4) consecutive weeks beginning the week of September 2, 2019, two (2) weeks beginning October 1, 2019 and once (1) beginning November 1, 2019. These Certified Nursing Assistant check off s will be completed to ensure that appropriate infection control practices are being followed. The Director of Nursing Services or Registered Nurse or Staff Development Nurse will complete a random competency skills check off of glove usage, hand hygiene and stoma site care weekly with one (1) Registered Nurse or License Practical Nurse for four (4) consecutive weeks beginning the week of September 2, 2019, two (2) weeks beginning October 1, 2019 and once (1) beginning November 1, 2019. These Registered Nurses and Licensed Practical Nurses check off s will be completed to ensure that appropriate infection control practices are followed. Staff Development Nurse will complete a competency skills check off with Certified Nursing Assistant (CNA) during	

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F 656	Continued From page 11 applied the gauze around the tubing and stoma site. RN #1 put a piece of tape onto the sponge to secure the dressing to the skin. RN #1 did not date or initial the dressing. RN #1 picked up Resident #38's covers and placed them back over her. RN #1, using the same gloves, attempted to roll Resident #38 over in the bed with the assistance of LPN #1. RN #1 loosened the tape on Resident #38's brief to begin wound care to her coccyx. RN #1 realized she needed to go to the other side of the bed to assist Resident #38 over on to her left side so she could see the coccyx better from the right side. RN #1 moved the bed and went to the other side of the bed handling the brakes on the bed with her gloved hands and then handling the linens on the bed. RN #1 started back around the bed and she picked up trash on the floor at the foot of the bed. RN #1 threw the trash away and continued care with the same gloves on. RN #1 returned to the right side of Resident #38 pulling up on Resident #38's hip to view the coccyx. RN #1 kneeled down to view the coccyx taking her gloved hands and touching the hips and buttocks. RN #1 stated "the wound is closed so I want to use a different treatment on the wound. I need to go call the Nurse Practitioner and get a new order for a different treatment". RN #1 removed her gloves, washed her hands, dried her hands with a paper towel and turned the faucet off with the same gloves. RN #1 gathered trash and placed it in the red biohazard bag and exited the room placing the red biohazard bag into another red biohazard bag on her wound care cart. RN #1 pushed the wound care cart down the hall toward the nursing station stating, "I'm going to call the Nurse Practitioner now". RN #1 did not wash her hands after handling the trash and red biohazard bag.	F 656	orientation that will include hand washing and proper use of gloves while providing incontinent care and perineal care. Director of Nursing and Staff Development Nurse will complete a competency skills check off with Registered Nurses and Licensed Practical Nurses during orientation that will include glove usage, hand hygiene and stoma site care. Findings of this validation check offs performed by the direct care staff will be discussed monthly with the Administrator. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been met.	

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	255303	A. BUILDING _____ B. WING _____	08/29/2019

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F 656	Continued From page 12 An interview, on 8/29/19 at 8:30 AM, revealed RN #1 stated, "I didn't realize I touched the faucet with the same paper towel until you told me. I did realize I touched the curtain and should have rewashed my hands. I do remember picking the trash up and continuing care with my gloves, but I didn't think about it until now. I remember rubbing the area around the stoma several times with the same gauze and I remember turning it over. I did turn the gauze around and around on the tubing. I was just so nervous. I stayed up last night remembering things I should have done better. I don't think I followed the care plan because I didn't do the care correctly. An interview, on 8/29/19 at 10:30 AM, with Licensed Practical Nurse (LPN) #2/ Minimum Data Set (MDS) Care Plan Nurse revealed "my expectations is for the staff to follow a care plan and to follow it correctly". An interview, on 08/29/19 at 11:15 PM, with the Director of Nursing (DON) revealed, "the care plan is the plan of care for each resident. Anything put in place on a care plan should be followed in the care of the resident. RN #1 did not follow the care plan with Enteral Feeding/Stoma Care".	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		10/1/19

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F 690	Continued From page 13 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide incontinent care to prevent the possibility of cross contamination and/or a Urinary Tract Infection (UTI), for one (1) of two (2) residents observed for incontinent care, Resident #33 Findings include:	F 690	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #33 was assessed on August 28, 2019 by the Director of Nursing with no sign or symptoms of infection noted and with no negative outcome. Certified Nursing Assistant (CNA #1) failed to follow the policy concerning infection control practices to include proper use of gloves	

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F 690	Continued From page 14 A review of the facility's policy titled, "Incontinent Care", without a date, revealed it was the policy of the facility to provide routine preventive skin and perineal care to residents after incontinent episode. The policy listed in the steps to remove gloves and discard, wash hands and apply clean gloves after discarding soiled towels and linen. An observation on 08/26/19 at 9:18 AM revealed a strong urine smell in Resident #33's room. An observation on 08/28/19 at 04:51 PM with Certified Nursing Assistant (CNA) #1 revealed that during perineal care for Resident #33 used peri-wipes wiping front to back once and threw away. CNA #1 turned resident over and wiped over the buttocks and sacrum without changing gloves. CNA #1 then removed her gloves and put on a new pair of gloves without performing hand hygiene. A new brief was put on Resident #33 by CNA #1 and repositioned resident. CNA #1 removed her gloves and performed hand hygiene. An interview on 08/28/19 at 4:53 PM with CNA #1 revealed she had just been hired two weeks ago and had completed a competency skills check off during orientation that included perineal care. CNA #1 said the policy of the facility was to wash hands between going from dirty to clean and said she should have washed her hands. CNA #1 said the concern was cross contamination. An interview on 8/28/19 at 5:30 PM with Director of Nursing (DON) revealed the policy of the facility was to perform the hand hygiene between dirty and clean to prevent the possible spread of	F 690	and hand washing while providing incontinent care and perineal care. In-service and competency skill check off for proper use of gloves and hand washing while providing incontinent care and perineal care was performed by Certified Nursing Assistant (CNA#1) and evaluated by the Staff Development Nurse on August 30, 2019. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that require incontinent care and perineal care have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program concerning infection control practices to include proper use of gloves and hand washing while providing incontinent care and perineal care was began on August 30, 2019 by the Staff Development Nurse for the Certified Nursing Assistants (CNA s). Competency skills check off s for incontinent care and perineal care by the Director of Nursing or Staff Development Nurse began on August 30, 2019 with the Certified Nursing Assistants (CNA s). An in-service education program was done on September 20, 2019 by the	

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F 690	Continued From page 15 infection. A review of Resident # 33's comprehensive care plan revealed the resident had a problem with bowel and bladder incontinence and needed assist with perineal cleansing as needed. A review of Resident # 33's Minimum Data Set with an Assessment Reference Date of 7/15/19 revealed resident was always incontinent.	F 690	Director of Nursing and Staff Development Nurse for nursing staff concerning infection control practices to include proper use of gloves and hand washing while providing incontinent care and perineal care. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services or Registered Nurse or Staff Development Nurse will complete a random competency skills check off of proper use of gloves and hand washing while providing incontinent care and perineal care weekly with three (3) Certified Nursing Assistant (CNA s) for four (4) consecutive weeks beginning the week of September 2, 2019, two (2) weeks beginning October 1, 2019 and once (1) beginning November 1, 2019. These Certified Nursing Assistant check off s will be completed to ensure that appropriate infection control practices are being followed. Staff Development Nurse will complete a competency skills check off with Certified Nursing Assistant (CNA) during orientation that will include proper use of gloves and hand washing while providing incontinent care and perineal care. Findings of this validation check offs performed by the direct care staff will be discussed monthly with the Administrator. The Quality Assurance monthly meeting	

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F 690	Continued From page 16	F 690	will make recommendations and changes as needed until such time consistent substantial compliance has been met.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide Resident #38's Percutaneous Endoscopic Gastrostomy (PEG) tube site care in a manner to prevent the possibility for cross contamination and/or infection. This concern was identified for one (1) resident observed for PEG tube site care out of a total of four (4) wound care	F 693	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #38 was assessed on August 29, 2019 by the Director of Nursing with no signs or symptoms of infection noted and with no negative outcome.	10/1/19

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F 693	Continued From page 17 observations. Findings Include: Review of a typed statement on the facility's letterhead, dated August 25, 2019, and signed by the Director of Nurses (DON), revealed the facility did not have a policy for stoma site care. A review of facility's policy titled, "Dressing Change" not dated, revealed, "A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound healing". An observation, on 08/28/19 at 2:25 PM, revealed Registered Nurse (RN) #1 entered Resident #38's room to provide Enteral Feeding Care and stoma (site) care. RN #1 put gloves on as she was standing in the hall at the wound care cart. RN #1 wiped the tray with Sani-cloth bleach wipes. RN #1 removed her gloves and entered Resident #38's room. Licensed Practical Nurse (LPN) #1 entered the room to assist RN #1 in positioning the resident. RN #1 placed a red bag inside the garbage can by the Resident #38's bed. RN #1 placed a paper towel on the over bed table and placed the tray containing the supplies on the paper towel. RN #1 washed her hands and dried her hands with a paper towel and then used the same paper towel to turn the faucet off. RN #1 pulled the divider curtains between Resident #38's bed and her roommate's bed. RN #1 gloved and stated, "I should have washed my hands again after touching the curtains and gloving". RN #1 kept the gloves on and continued to provide care. RN #1 removed the soiled dressing from around the PEG tube stoma and placed it in the	F 693	Registered Nurse (RN#1) failed to follow the policy concerning infection control practices to include hand washing and stoma site care. In-service and competency skill check off for hand washing, and stoma site care was performed by Director of Nursing on August 30, 2019 for Registered Nurse (RN#1). 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents that need stoma site care have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program concerning infection control relating to hand washing and stoma site care was began on August 30, 2019 by the Director of Nursing with Registered Nurses and License Practical Nurses. Competency skills check off s for hand washing and stoma site care by the Director of Nursing and Staff Development began on August 30, 2019 with Registered Nurses and License Practical Nurses. An in-service education program was done on September 20, 2019 by the Director of Nursing concerning infection	

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F 693	Continued From page 18 red biohazard bag. RN #1 removed her gloves, washed her hands and dried them with a paper towel and then used the same paper towel to turn the faucet off. RN #1 gloved, opened a pack of gauze, and took the gauze from the packet holding the gauze in her gloved hand. RN #1 poured normal saline onto the gauze she was holding in her hand. RN #1 took the gauze and wiped around the stoma, holding the tubing in the left hand, in a dabbing motion from one side of the stoma to the other side. RN #1 turned the gauze over and continued to wipe the stoma again. RN #1 took the gauze and rubbed an area on each side of the stoma trying to get dried exudate removed from the skin using the same gauze. RN #1 discarded the gauze in the red biohazard bag. RN #1 opened another pack of gauze, holding it in her gloved hand, and poured normal saline onto the gauze. RN #1 wiped the tubing in a circular motion, using the same spot on the gauze, around the tubing from the point of entry into the stoma continuing all the way up the tubing. RN #1 removed her gloves, washed her hands, dried her hands with a paper towel and used the same paper towel to turn the faucet off. RN #1 gloved, opened a sponge gauze and applied the gauze around the tubing and stoma site. RN #1 put a piece of tape onto the sponge to secure the dressing to the skin. RN #1 did not date or initial the dressing. RN #1 picked up Resident #38's covers and placed them back over her. RN #1, using the same gloves, attempted to roll Resident #38 over in the bed with the assistance of LPN #1. RN #1 loosened the tape on Resident #38's brief to begin wound care to her coccyx. RN #1 realized she needed to go to the other side of the bed to assist Resident #38 over on to her left side so she could see the coccyx better from the right side. RN #1 moved	F 693	control to include hand washing and stoma site care for nursing staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services or Registered Nurse or Staff Development Nurse will complete a random competency skills check off of hand washing and stoma site care weekly with one (1) Registered Nurse or License Practical Nurse for four (4) consecutive weeks beginning the week of September 2, 2019, two (2) weeks beginning October 1, 2019 and once (1) beginning November 1, 2019. These Registered Nurses and Licensed Practical Nurses check off s will be completed to ensure that appropriate infection control practices are followed. Director of Nursing and Staff Development Nurse will complete a competency skills check off with Registered Nurses and Licensed Practical Nurses during orientation that will include hand washing and stoma site care. Findings of this validation check offs performed by the direct care staff will be discussed monthly with the Administrator. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been met.	

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F 693	Continued From page 19	F 693		

the bed and went to the other side of the bed handling the brakes on the bed with her gloved hands and then handling the linens on the bed. RN #1 started back around the bed and she picked up trash on the floor at the foot of the bed. RN #1 threw the trash away and continued care with the same gloves on. RN #1 returned to the right side of Resident #38 pulling up on Resident #38's hip to view the coccyx. RN #1 kneeled down to view the coccyx taking her gloved hands and touching the hips and buttocks. RN #1 stated "the wound is closed so I want to use a different treatment on the wound. I need to go call the Nurse Practitioner and get a new order for a different treatment". RN #1 removed her gloves, washed her hands, dried her hands with a paper towel and turned the faucet off with the same gloves. RN #1 gathered trash and placed it in the red biohazard bag and exited the room placing the red biohazard bag into another red biohazard bag on her wound care cart. RN #1 pushed the wound care cart down the hall toward the nursing station stating, "I'm going to call the Nurse Practitioner now". RN #1 did not wash her hands after handling the trash and red biohazard bag.

An interview, on 8/29/19 at 8:30 AM, with RN #1 revealed, "I didn't realize I touched the faucet with the same paper towel until you told me. I did realize I touched the curtain and should have rewashed my hands. I do remember picking the trash up and continuing care with my gloves, but I didn't think about it until now. I remember rubbing the area around the stoma several times with the same gauze and I remember turning it over. I did turn the gauze around and around on the tubing. I was just so nervous. I stayed up last night remembering things I should have done better. I guess all of this would be an infection control

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F 693	Continued From page 20 issue". An interview, on 8/29/19 at 11:13 AM, revealed the Director of Nursing (DON) stated, "RN #1 not performing Percutaneous Endoscopic Gastrostomy (PEG) stoma care properly was improper technique according to our policy. RN #1 should have used one gauze for each wipe made around the stoma and with the tubing. It could have caused the spread of infection with her using one gauze for multiple wipes". Review of the facility's Education Training In-service, dated 4/19/19, revealed RN #1 attended an in-service on infection control, handwashing, universal precautions, and contaminated clothing policy. Review of the facility's Education Training In-service, dated 8/23/19, revealed RN #1 attended an in-service on Handwashing practices and infection control. An interview, on 8/29/19 at 1:13 PM, revealed the DON reported she cannot find a check-off competency for RN #1 regarding PEG tube care including stoma care.	F 693		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		10/1/19

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F 758	Continued From page 21 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide a Gradual Dose Reduction for (2) of five (5) Residents reviewed for Psychotropic medication use, Residents #51, and #23. Findings include: A Review of the facility policy titled "Gradual Dose Reduction of Psychotropic Drugs" dated 5/3/18 revealed, "Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs". Definitions: "Gradual Dose Reductions (GDR)" is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. "Psychotropic Drug" is defined as any drug than affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics. Resident #51 Review of the Physician Telephone Orders, revealed an order, dated 6/5/18 for Abilify 2 milligrams (mg) daily. Further review of the orders, revealed an order, dated 4/6/18, for Lexapro 10mg daily. Review of the August 2019 Physician's Orders revealed the orders for Lexapro 10mg by mouth daily and Abilify 2mg tab by mouth every other day. Both medications were ordered for Major	F 758	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility failed to provide proof of a Gradual Dose Reduction of Psychotropic Drugs for Resident #51 and #23. The Director of Nursing notified the Medical Director and Nurse Practioner on August 29, 2019 of the failure to provide proof of gradual dose reduction of Psychotropic Drugs concerning Residents #51 and #23 with no medication changes made at this time. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents that are on Psychotropic Drugs have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program concerning Gradual Dose Reduction of Psychotropic Drugs was completed August 30, 2019 by the Director of Nursing with Registered Nurse Supervisor. An in-service education program was done on September 20, 2019 by the Director of Nursing concerning Gradual	

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	255303	A. BUILDING _____ B. WING _____	08/29/2019

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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F 758	Continued From page 23 Depressive Disorder. The facility failed to produce a Gradual Dose Reduction (GDR) for either Psychotropic medication. An interview, on 8/29/19 at 11:10 AM, with the Director of Nursing (DON) revealed, "There should be a GDR on all Psychotropic medications. The consultant pharmacy recommends GDRs and we are supposed to follow through with them. We could not find the GDRs on the Lexapro or the Abilify. There were none available in Resident #51's medical record." Resident #23 Review of the August 2019 Physician Orders revealed the included diagnoses: Dementia, Major Depressive Disorder, and Anxiety Disorder. Review of the August 2019 Physician's Orders revealed Resident # 23 was on the following medications: Memantine HCL 10 mg tablet give by mouth twice daily for Dementia, Alprazolam 0.25 mg give on (1) tablet by mouth once daily at bedtime for Anxiety, and Paroxetine HCL 30 mg give one (1) tablet by mouth once daily for anxiety. Review of the Minimum Data Sheet (MDS) revealed the following diagnosis: Non-Alzheimer's Dementia, Anxiety Disorder, and Dementia in other diseases classified elsewhere with behavioral disturbances. On 08/29/19 at 10:30 AM, an interview with the Director of Nursing (DON) revealed she was unable to find the Gradual Dose Reduction (GDR) for Resident # 23.	F 758	Dose Reduction of Psychotropic Drugs for nursing staff. On receipt of pharmacy recommendations, the Psychiatric Nurse Practioner will be notified per the Director of Nursing to address all recommendations to include Gradual Dose Reduction of Psychotropic Drugs per Medical Director or Nurse Practioner approval. Any recommendations requiring action thereafter will be addressed by the Nurse Practioner during her weekly rounds or Medical Director on his rounds beginning September 20, 2019. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services or Registered Nurse Supervisor will complete an audit of residents on Psychotropic Drugs beginning September 4, 2019 to ensure that Gradual Dose Reductions of Psychotropic Drugs were addressed. The Director of Nursing or Registered Nurse Supervisor will audit once a month for three (3) months beginning September 4, 2019. Findings of the audit will be discussed monthly with the Administrator. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been met.	

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F 803	Continued From page 24	F 803		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, resident interview and facility policy review, the facility failed to honor Resident #44's food preferences, for one (1) of 19 resident dining observations. Findings include:	F 803	Immediate action(s) taken for the resident(s) found to have been affected include: Dietary Manager discussed food preference with Resident #44 on August 28, 2019 and made corrections to Dietary tray card concerning broccoli and all other food likes and dislikes.	10/1/19

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F 803	Continued From page 25 A review of the facility's policy titled, "Alternate Foods for Food Preferences", with a revised date of 8/17, revealed the facility would serve food or beverages to meet individual resident food allergies, intolerance's, preferences or requests. An interview and observation, on 8/26/19 at 11:51 AM, revealed Resident #44 stated she told the staff last week she didn't like broccoli and then pointed to it on her plate. Resident #44 said she didn't usually like spaghetti, but they didn't offer an alternative. A review of Resident #44's tray card revealed the card did not list any likes or dislikes. A review of Resident #44's current Comprehensive Care Plan revealed an intervention to offer food alternatives when appropriate for any meal and to maintain a list of food likes and dislikes. A review of the August 2019 Physician's Orders revealed an order for a Low Concentrated Sweets (LCS) diet. An interview, on 8/28/19 at 2:16 PM, with the Dietary Manager (DM) revealed she completed the initial assessment on Resident #44. The DM said the preferences and dislikes would be entered by her into the computer. The DM said when she is notified after she has completed the assessments, she would enter those in the computer as soon as she knew about it. The DM also said the tray cards would have the dislikes listed with a (D) beside the food item. The DM confirmed Resident #44 did not have any listed on her tray cards. The DM said the server and the dietary aide would see the tray card during the	F 803	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that have food preferences have the potential to be affected by the deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Dietary staff were in-serviced August 30, 2019 on Resident Rights/Quality of Life and Food Preferences by the Dietary Manager. The Dietary Manager interviewed Residents concerning their food preferences beginning August 30, 2019 to ensure their food preferences are honored. A Validation Checklist was completed by the Dietary Manager on September 3, 2019 to determine if food preferences for six random residents were notated on meal tickets and during meal service. An in-service education program was done on September 20, 2019 by the Director of Nursing concerning Resident food likes and dislikes with the nursing staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or Dietary Manager will complete a Validation Checklist 2 x's a week for 2 weeks then weekly for 2 weeks then monthly for 2 months to determine if food preferences were notated on meal	

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F 803	Continued From page 26 tray line. The DM said she was not aware Resident # 44 did not like broccoli. The DM also confirmed the care plan said to follow the resident's preferences and agreed the resident has the right to her preferences. A review of Resident #44's Minimum Data Set, with an Assessment Reference Date of 8/14/19, revealed her Brief Interview for Mental Status (BIMS) was 15, which indicated the resident was cognitively intact.	F 803	tickets and during meal service. Findings will be reviewed with Administrator monthly to ensure menus meet resident food preferences. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been achieved as determined by the committee.	

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	255303	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2019**

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K 000	INITIAL COMMENTS The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 09/26/2019

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.

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E 000	Initial Comments ********** Survey conducted on 08/30/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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