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 _____	01/12/2018

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 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 1/8/18 to 1/12/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F 0561, F 0641, F 0657, F 0658, F 0755, F 0802 and F 803. At the time of the survey, the census was 55, and the facility held a license for 60 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		2/20/18

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

Electronically Signed | 02/16/2018

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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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to honor resident food preferences for one (1) of four (4) residents observed and interviewed for food choices; Resident #28. Findings include: A review of the facility's policy entitled, "Resident Rights", undated, revealed a resident has the right to have input into your assistance/service plan which guides the services delivered to you. Resident also has the right to recommend changes in policies and services. Review of the booklet entitled, "A Matter of Rights", which is given to each resident upon admission, revealed the resident has the right to freedom of choice in the medical decisions they make and may exercise this right free from interference, coercion, discrimination, or reprisal. Resident #28 Review of the dietary notes for the most recent quarterly assessment revealed an interview was conducted with Resident #28 to update preferences. In that interview with the Dietary Manager, Resident #28 stated she did not want meat to be sent on the tray. Interview and observation on 01/08/18 at 12:27	F 561	F 561 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 28 was assessed by the Director of Nurses on 01/11/2018 to ensure there was no negative outcome related to receiving meat on her tray. Resident denied complaints. The Administrator in-serviced the Dietary manager on 01/11/2018 to ensure preferences for likes and dislikes of food and drinks is indicated on resident #28□s meal ticket and corrections were made. 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. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Dietary staff were in-serviced on the facility□s Residents' Food Preference policy and procedure and Resident Rights by Dietary Consultant on 02/14/2018. The Dietary Manager interviewed 25 Residents 02/13/2018 through 02/15/2018 for food preferences. A Validation	

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F 561	Continued From page 2 PM, revealed Resident #28 stating the facility serves meat at meals and she does not eat meat. Resident #28 further revealed she has not eaten meat in a long time. The current meal observation revealed Resident #28 was served meat and the menu listed it as country fried steak. On 01/11/18 at 03:01 PM, Resident #28 revealed to a different surveyor that she does not eat meat or eggs. On 01/12/18 at 09:47 AM, Resident #28 revealed that she had bacon on her tray this morning. In an interview on 01/11/18 at 02:31 PM, the Dietary Manager revealed she had discussed with the resident about her preference of not wanting meat and that it had been discussed in care plan. The Dietary Manager further revealed Resident #28's dislike for meat is not indicated on her meal ticket. An interview on 01/12/18 at 11:34 AM, with Certified Nursing Assistant (CNA) #1, revealed she delivered the breakfast tray to Resident #28 this morning. CNA #1 stated Resident #28 had "Rice Krispies, toast, bacon, orange juice, milk and coffee." An interview on 01/12/18 at 12:34 PM, with the Director of Nursing (DON), revealed "if a resident doesn't want something, I would expect for the resident's wishes to be honored." A review of the most recent quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/17, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.	F 561	Checklist was completed on 02/15/2018 by the dietary consultant determining if the dietary manager documented the likes and dislikes correctly on meal tickets. The facility will terminate the Dietary Manager on 2/19/2018. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, Registered Nurse Supervisor or Dietary Consultant will complete a Validation Checklist on Resident #28 and four other meal trays 2 x a week for 2 weeks then monthly for 2 months to determine if food preferences are honored. Validation Checklists will be reviewed by the Quality Assurance Committee monthly or until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 657	Continued From page 3	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to revise the care plan to address food preferences for one (1) of four (4) care plans reviewed; Resident #28. Findings include:	F 657	F 657 Immediate action(s) taken for the resident(s) found to have been affected include: Resident #28□s was assessed by the Director of Nurses on 1/11/2018 to ensure there was no negative outcome related to	2/20/18

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F 657	Continued From page 4 Review of the facility's policy entitled, "Care Plans", undated, revealed that each resident will have a care plan to identify problems, needs and strength that will identify how the interdisciplinary team will provide care. The Care Plan will be reviewed and/or revised at quarterly intervals in conjunction with the completion of Minimum Data Set (MDS) assessments and with changes in resident's condition as needed. Resident #28 A review of the comprehensive care plan for Resident #28 revealed a problem that addressed risk for alteration in nutritional status. Interventions on care plan did not include resident's preference not to have meat served on her meal tray. Review of the Dietary Notes for the last MDS, completed for Resident #28, revealed this resident preferred not to have meat on her meal trays. An interview on 01/12/18 at 10:00 AM, with Licensed Practical Nurse (LPN) #1, who works as a MDS Nurse, revealed that she performed the assessment on Resident #28 and was not aware of her dislike for meats. LPN #1 further revealed the Dietary Manager made her aware on 01/11/18, of Resident #28's like for chicken spaghetti casserole. Interview on 01/12/18 at 11:57 AM, with the MDS Nurse, revealed she completed the nutrition care plan for Resident #28. The MDS Nurse revealed that she used the dietary notes when completing the assessment and care plan for residents. Upon review of the dietary notes for the last	F 657	receiving meat on her tray. Resident denied complaints. Resident #28 care plan was updated by the Dietary Manager to reflect her food preferences on 1/15/2018. 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. Actions taken/systems put into place to reduce the risk of future occurrence include: The Dietary Manager was counseled by the Administrator and Corporate Nurse on 1/11/2018 ensuring the resident□s food preferences are care planned within 7 days after the completion of the Minimum Data Set. The Minimum Data Set nurse in-serviced the Dietary Manager on the facility□s care plan policy and procedure on 02/07/2018. The Minimum Data Set nurse audited 100 percent of care plans on 2/14/2018 to ensure residents with food preferences were care planned. How the corrective action(s) will be monitored to ensure the practice will not recur: Minimum Data Set nurse will complete a Quality Assurance audit on 10 care plans per week for two weeks then monthly for 2	

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F 657	Continued From page 5 assessment completed, and comparing it to the nutrition care plan on Resident #28, the MDS Nurse revealed that she did not see where the care plan was revised to address the resident's preference not to have meat on her tray. The MDS Nurse revealed it should have been on the care plan because "it's her preference."	F 657	months to verify residents with food preferences care plan has been updated. Validation checklists will be reviewed by the Quality Assurance Committee each month until such time consistent substantial compliance has been achieved as determined by the committee.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, facility policy review, the facility failed to give medications within the allotted time frames for one (1) of six (6) medication observations; Resident #46. Findings include: Review of the facility's policy entitled, "Medication Administration General Guidelines", undated, reads: Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications and professional standards of practice. Review of the "Perry & Potter Nursing Skills and Procedures", Eighth edition, revealed: Compare the name of the medication label with the computer. Reading the label the first time and	F 658	F 658 Immediate action(s) taken for the resident(s) found to have been affected include: Residents # 46 was observed for negative outcomes by the Director of Nurse on 01/09/2018. The resident had no identified negative outcomes. The Director of Nurses notified the physician of the medication errors on 1/09/18. The Physician was notified that resident #46 did not receive Carvedilol, Divalproex Sodium, Nefedipine, Furosemide, Omeprazole, and Iprat-Albut on 1/09/18 in allotted time frames. New orders received for resident #46 and these medications were given on 1/09/18 at 09:51 am by LPN #2. LPN #2 was immediately in-serviced on the facility□s Medication Administration Policy and Procedure by	2/20/18

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F 658	Continued From page 6 comparing it against the transcribed order reduces errors. Observation on 01/10/18 at 9:26 AM, revealed Licensed Practical Nurse (LPN) #2 administered Resident #46's 8:00 AM medications at 9:26 AM. Medications included: (1.) Carvedilol 6.25 milligram (MG) one (1) by mouth twice a day, (2.) Divalproex Sodium 500 MG one (1) by mouth twice a day, (3.) Nefedipine 30 MG one (1) by mouth daily, (4.) Furosemide 40 MG one (1) by mouth daily, (5.) Omeprazole 20 MG one (1) by mouth once daily, and Iprat-Albut 0.5-3 MG/3 ML, administer three (3) times a day. During interview on 01/10/18 at 9:45 AM, LPN #2 stated the medications are due at 8:00 AM and you have from 8:00 AM until 9:00 AM to administer the medications. LPN #2 also stated, it is a medication error to administer the medications after 9:00 AM. During interview on 01/11/18 at 11:15 AM, the Director of Nursing (DON) stated the facility decided the medication administration time for the hall that Resident #46 is on to be at 8:00 AM to give the nurses time to administer the medications. She also stated the nurses have from 7:00 AM until 9:00 AM to administer these medications. The DON stated if medications were administered at 9:26 AM, it's out of compliance, out of the time frame, and is called a medication error.	F 658	the Director of Nurses on 1/09/18. LPN #2 was checked off on medication administration by the Registered Nurse Supervisor on 1/10/2018. Identification of other residents having the potential to be affected was accomplished by: All residents on medications have the potential to be effected by this alleged deficient practice. Actions taken/systems put into place to reduce the risk of future occurrence include: The Nursing staff were in-serviced by the Staff Development Nurse and Corporate Nurse on the facility□s Medication Administration policy and procedure on 02/12/2018. Licensed nursing staff will be observed performing medication administration by the Pharmacy Consultant, Registered Nurse Supervisor, or Staff Development nurse 02/06/2018 and 02/09/2018 to ensure medications are given in allotted time frames, per policy and procedure. Newly hired nurses will be checked off during orientation. How the corrective action(s) will be monitored to ensure the practice will not recur: The Pharmacy Consultant, Registered Nurse supervisor, or the Staff Development nurse will observe nurses	

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F 658	Continued From page 7	F 658	performing medication passes beginning 02/12/2018, two times a week for two weeks then weekly for one month to ensure nurses are performing the procedure in accordance with our facility□s Medication Administration policy and procedure. The Director of Nurses and Registered Nurse Supervisor nurse will complete a Quality assurance audit on 5 medication administration records per week for four weeks to verify medications are given in the allotted time frames. Validation checklists will be reviewed by the Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		2/20/18

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F 755	Continued From page 8 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy, the facility failed to check the temperature of the refrigerator in the medication room for five (5) days out of 11 days for the month of January 2018. Findings include: Review of the policy titled, "Medication Storage", not dated, revealed medications requiring refrigeration must be stored between 36 degrees Fahrenheit and 46 degrees Fahrenheit in a refrigerator. A thermometer must be used for frequent monitoring . An observation on 01/11/18 11:09 AM, of the medication storage room, revealed a temperature log for the refrigerator was not updated for 5 (five) days out of 11 days for the month of January 2018. An interview on 01/11/18 at 02:48 PM, with the Director of Nursing (DON), revealed the	F 755	F755 Immediate action(s) taken for the resident(s) found to have been affected include: The facility did not identify residents affected by the deficient practices. Director of Nurses did an immediate review of medication refrigerator temperature log in the facility on 1/11/18. A 11-7 Nurse was in-serviced on 02/01/2018 by the Director of Nurses to review the medication temperature log for accuracy of temperatures are documented every day. Identification of other residents having the potential to be affected was accomplished by: The facility has identified that all residents have the potential to be affected by this alleged deficient practice. Actions taken/systems put into place to	

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F 755	Continued From page 9 temperature logs should be checked by night shift nurses. The DON stated, "I am responsible for making sure the logs are filled out everyday". The DON revealed she has been training someone to help with these tasks. The DON stated, "I just have not been in there to check the temperature logs." An interview on 01/12/18 at 02:42 PM, with the Registered Pharmacist (RPH), revealed the pharmacy consultants check the temperature logs when they arrive in the facility and it is the facility's responsibility to keep temperature logs updated.	F 755	reduce the risk of future occurrence include: The Director of Nurses in-serviced the nurses on the Medication Storage Policy and Procedure 02/13/2018. The 11/7 nurses were instructed to log the medication refrigerator temperatures every night as part of their job duties. A 11-7 Nurse was in-serviced on 02/01/2018 by the Director of Nurses to review the medication temperature log to ensure accuracy of temperatures are documented every day. The Registered Pharmacist will check the medication refrigerator temperature log during her monthly visits to ensure the temperature logs are updated. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nurses and/or Registered Nurse Supervisor will review the medication refrigerator log daily for one week then 2 times a week for 4 weeks, then weekly for 2 months to ensure accuracy of temperatures for medications storage are documented per policy. The results of the audit will be reported, reviewed, and trended for compliance by the Quality Assurance Committee monthly or until such time consistent substantial compliance has been achieved as determined by the committee.	
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b)	F 802		2/20/18

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F 802	Continued From page 10 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure staff were able to use and calibrate correct food thermometers and acknowledge and correct thermometer temperature; and failed to provide reference ranges for a three (3) compartment sink and dishwasher, for two (2) of (2) dietary tours. Findings include: Review of the facility's policy, "Guidelines For Using Thermometers", with a revision date of 02/17, revealed thermometers are calibrated before each use. The type of thermometers used include the bimetallic stemmed thermometer, thermocouples/themistors and infrared/laser thermometers. The bimetallic stemmed	F 802	F 802 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility did not identify residents affected by the deficient practices. Dietary Manager was in-serviced on Calibration of Thermometers policy and procedure by the Administrator and Corp Nurse on 1/11/18. The Dietary Manager in-serviced the dietary staff on Calibration of Thermometers policy and procedure on 1/26/2018. The Dietary Manager and Dietary Staff were in-serviced and checked off on the proper procedures for Calibration of food thermometers and Safe Food Handling Practices/Food Temperatures by the Dietary Consultant	

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F 802	Continued From page 11 thermometer uses a calibration nut to calibrate the thermometer at least in two (2) degree increments to measure large amounts of food. Review of the "Auto-Chlor System" policy related to dishmachine temperatures, undated, revealed the Parts Per Million (PPM) temperate reading for the sanitizer should be at 50 Parts Per Million (PPM). Review of the facility's policy related to Manual Warewashing, with a revision date of 02/17, revealed the third sink, if using chemical sanitizing, the sanitizer must be mixed to the proper concentration. Follow the manufacture recommendations. The employee immersing the test strip into the chlorine solution for seven (7) seconds in the 100 degree Fahrenheit water, and records the PPM on the "Pot and Pan Sink Chemical/Temperature Log." Review of the facility's policy, "Machine Warewashing", undated, revealed Chlorine Sanitizing Machines use a chlorine sanitizing machines use a low temperature to clean and sanitize. The sanitizer concentration should be 50-99 PPM. The chlorine concentration is documented on the "Machine Warewashing Temperature Log". Observation and staff interview, on 01/11/18 at 11:05 AM, revealed Dietary Cook #3 saying she needed to calibrate the food thermometer to 39 degrees Fahrenheit, in order to obtain the steam table food temperatures. Dietary Cook #2 said she needed to calibrate the food thermometer to 30 degrees Fahrenheit in order to obtain the steam table food temperatures. Each dietary cook placed the thermometer in a glass of ice	F 802	on 1/24/18. The Dietary Consultant in-serviced on proper temperature and sanitizing solution levels for dish machine and three compartment sink on 02/14/2018. The Dietary Manager did skills assessment/Evaluation on dietary staff 02/14/2018 and 02/15/2018 for Thermometer and checking PPM range for dish machine and three compartment sink. The Auto-Chlor representative in-serviced 01/12/2018 the dietary staff on the correct reference ranges of the parts per million "PPMs", and what to do when the PPM range for the third compartment sink and dishwasher is not in the required ranges. A procedure for the PPM reference ranges and what to do when the PPMs are out of the required range was posted in the dishwashing room on 1/12/18. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents served meals have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Dietary Manager was in-serviced on Calibration of Thermometers policy and procedure by the Administrator and Corp Nurse on 1/11/18. The Dietary Manager in-serviced the dietary staff on Calibration of Thermometers policy and procedure on 1/26/18. Dietary Staff were in-serviced on the Calibration of thermometers and Safe Food Handling practices/Food	

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	255303	A. BUILDING _____ B. WING _____	01/12/2018

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 802	Continued From page 12 water and said they were waiting for the thermometer to drop to the degrees each one stated. The Dietary Manager attempted to calibrate the thermometer and observed the thermometer's reading began at 50 degrees Fahrenheit, and said the thermometer was not the correct food thermometer. She got another food thermometer for which Dietary Cook #3 and Dietary Cook #2 attempted to use the attached wrench, by placing the thermometer in the barrel and not in the wrench's opening. Each one said they could not calibrate the food thermometer. The Dietary Manager attempted to calibrate the thermometer with the thermometer wrench out of the ice water, then placed it back into the cup of ice water, several times while waiting for the thermometer to reach 32 degrees Fahrenheit. Observation and staff interview, on 01/12/18 at 11:35 AM, revealed Dietary Manager (DM) observed Dietary Cook #3 obtaining the PPM of the third compartment sink - rinse sink, which contained the Auto Chlor Sanitizer. Dietary Cook #3 said the reading was 200 PPM. When asked what was the normal range for the PPM, the DM and Dietary Cook #3 replied, they did not know. When the DM replied to whether the facility had a chart with the ranges for Auto Chlor Sanitizer, she confirmed she did not have one. Observed DM looking under the sink at the containers of Auto Chlor Sanitizer for the recommended PPM. There were no recommended PPM listed on the containers. The DM confirmed the staff failed to use the correct food thermometer, and failed to correctly calibrate the food thermometer to 32 degrees Fahrenheit using the calibration wrench on 01/11/18. The DM stated she recently ordered new thermometers, but did not realize that they started at 50 degrees Fahrenheit and were the	F 802	temperatures policy and procedures on 1/24/18 by the Dietary Consultant. In-service training and a validation checklist was completed on dietary staff performing the calibration of thermometers on 02/14/2018 and 02/15/2018 by the Dietary Consultant. Thermometer calibration check off dietary staff on 2/6/2018 through 2/13/2018 by Dietary Manager. A Validation Checklist was completed for dietary staff to determine if the dietary staff was performing correct procedure for checking the PPMs ranges for the third compartment sink and dishwasher on 02/11/2018 and 02/13/2018 by Dietary Manager and 02/15/2018 by the Dietary Consultant. New dietary staff will be in-serviced to be capable of thermometer calibration and checking the PPM□s required ranges. A procedure was posted for the PPM reference ranges and what to do when the PPMs are out of the required ranges in the dishwashing room on 1/12/18 by the Dietary Manager. The facility will terminate the Dietary Manager on 2/19/18. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or Dietary Consultant or Interim Dietary Manager will complete Validation Checklists of dietary staff performing Calibration of food thermometers and checking the PPMs for third compartment sink and dishwasher in accordance with the facility policy and procedures 3 x a week for 2 weeks then	

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F 802	Continued From page 13 wrong type of thermometers for obtaining food temperatures. Staff interview, on 01/12/18 at 11:45 AM, with Dietary Staff #4, revealed she recorded the PPM of the rinse cycle of the dishwashing machine, and confirmed she would call the maintenance staff to turn-up the water pressure if the PPM was not reading 50 PPM. Said she did not know the the acceptable ranges for the PPM of the dishwasher machine. Staff interview, on 01/12/18 at 11:45 AM, with Dietary Staff #5, revealed him loading dishes into the dishwashing machine. He stated that he worked in the dishwashing area and does not record the PPM and does not know anything about the sanitization process or recording of the PPM. Staff interview, on 01/12/18 at 11:50 AM, with the Dietary Manager, revealed/confirmed there were no PPM charts in the dishwashing areas to alert staff of the correct PPM ranges, and of what to do when the PPM were out of the recommended ranges. She confirmed the dietary staff failed to know the recommended PPM ranges and of what actions to take when the ranges where not met. Staff interview with the Registered Dietician (RD), on 01/12/18 at 01:35 PM, revealed she comes to the facility once a month and spends time in the dietary department checking the sanitizer and temperature logs. She stated on her last visit she observed there being problems with the food thermometers and told the Dietary Manager to order new ones. She stated the DM is responsible for conducting in-services for the dietary staff and she performed inservices with	F 802	weekly for 2 weeks and monthly for 2 months. Validation Checklists will be reviewed by the Quality Assurance Committee monthly and/or until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 802	Continued From page 14 the dietary staff only when problems arise and the Dietary Manager needed assistance. The Registered Dietician said there should be a poster in the dishwashing room to give staff a reference range of the correct PPM's, and what to do when the PPM's are out of the required ranges.	F 802		
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:	F 803		2/20/18

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F 803	Continued From page 15 Based on observation, staff interview, resident interview, record review, and facility policy review, the facility failed to revise the menu to accommodate residents' request for food preferences for one (1) of four (4) residents observed and interviewed for food choices, Resident #28. Findings include: A review of the facility's policy entitled, "Menus", revised 06/16, revealed individual meal plans are adjusted for individual differences. Foods will be served as planned on the menu unless there is a legitimate or extenuating circumstance. If a deviation from the planned meal occurs, the Dietary Manager makes the appropriate changes directly on a copy of the menu. Review of the facility's policy entitled, "Resident Rights", undated, revealed a resident has the right to have input into your assistance/service plan which guides the services delivered to you. Resident also has the right to recommend changes in policies and services. Resident #28 A review of the dietary notes for the most recent quarterly assessment revealed an interview was conducted with Resident #28 to update preferences. In that interview with the Dietary Manager, Resident #28 stated she did not want meat to be sent on her tray. Review of the breakfast meal ticket, dated 01/12/18, revealed Resident #28 was served sausage and eggs for breakfast. There was no indication on the meal ticket menu for resident's preference not to be served meat.	F 803	F 803 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 28 was assessed by the Director of Nurses on 01/11/2018 to ensure there was no negative outcome related to receiving meat on her tray. Resident denied complaints. The Administrator and Corp Nurse in-serviced the Dietary manager on 1/11/18 to ensure preferences for likes and dislikes of food and drinks is indicated on resident #28□s meal ticket and corrections were made. 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 02/14/2018 on Resident Rights, Food Preferences, and adjusting meal plans/menus according to individual differences. A Validation Checklist was completed by the Dietary Consultant on 02/14/2018 to determine if food preferences for six residents were notated on meal tickets and during meal service. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or	

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F 803	Continued From page 16 An interview and observation on 01/08/18 at 12:27 PM, revealed Resident #28 stating the facility served meat at meals and she does not eat meat. The current meal observation revealed Resident #28 was served meat and the menu listed it as country fried steak. On 01/11/18 at 03:01 PM, Resident #28 stated to a different surveyor that she did not eat meat or eggs. On 01/12/18 at 09:47 AM, Resident #28 stated that she was served bacon on her tray this morning. In an interview, on 01/11/18 at 02:31 PM, the Dietary Manager revealed she had discussed with the resident about her preference of not wanting meat and that it had been discussed in care plan and was brought up during survey last year. The Dietary Manager confirmed Resident #28's dislike for meat was not indicated on her meal ticket/menu. Interview on 01/12/18 at 11:34 AM, with Certified Nursing Assistant (CNA) #1, revealed she delivered a breakfast tray to Resident #28 this morning, which included bacon and eggs. Review of the most recent quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/05/17, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	F 803	Dietary Consultant will complete a Validation Checklist 2 x's a week for 2 weeks then monthly for 2 months to determine if food preferences were notated on meal tickets and during meal service. Findings will be reviewed with Dietary Manager to ensure menus meet resident needs. Validation Checklists will be reviewed by the Quality Assurance Committee monthly or 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 _____	**01/12/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 101 section 19.2.2.2.6. This standard deficiency affected one (1) of seven (7) exits and 19 of 55 residents in the facility on the day of survey. Findings include: On January 12, 2018 at 10:25 AM, observation revealed wheelchairs and soiled linen barrels obstructing the egress from the exit near the Kitchen of the facility.	K 211	FIRE SAFETY Received FEB 20 2018 MSDH-HFLC & CONSTRUCTION 2-20-18 Accepted By [signature] K211 The wheelchairs and soiled linen barrels were immediately removed 1/12/18 from obstructing the egress from the exit near the kitchen. All Residents have the potential to be effected by the alleged deficient practice. Staff in-serviced on keeping the wheelchairs and soiled linen barrels from obstructing the egress from the exit near the kitchen of the facility by the Administrator on 1/12/18. Housekeeping Staff or Dietary Staff will perform an inspection 3 x a week for 2 weeks, then weekly for one month to	2/20/18

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

Electronically Signed | 02/16/2018

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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	255303	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/12/2018**

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K 211	Continued From page 1	K 211	ensure that wheelchairs and linen barrels are not obstructing the egress from the exit near the kitchen of the facility. The Administrator will review the validation checklists weekly and bring before the Quality Assurance Committee monthly and or until such time consistent substantial compliance has been achieved as determined by the committee.	