MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 000	Initial Comments Complaint Investigation (CI) MS #16700; CI MS #17180; and CI MS #17252 The State Agency (SA) conducted a complaint survey on 5/26/21. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm. Complaint Investigation (CI) MS #17180 was substantiated and cited M 225 for staffing ratio. CI MS #16700 related to a fall with a head injury and CI MS #17252 for alleged abuse and neglect were not substantiated. The facility's census was 55 at the time of the survey.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in	M 225		7/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 1 the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II Substantiated CI MS #17180 Based on record review, staff interviews, family	M 225	1. Immediate action(s) taken for the resident(s) found to have been affected include: March of 2021, the facility increased the compensation package for nursing staff,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 2 interviews, and resident interviews, the facility failed to maintain the minimum requirements for staffing ratios of 2.8, for two (2) days in March 2020 and for 12 days in September 2020 as per the anonymous complaint, CI MS #17180, that was reported to the State agency. Findings include: The facility policy and procedure for staffing ratios was requested for review. In lieu of the staffing policy, the facility administrator submitted on letterhead a statement that read: "(Name of facility) does not have a policy that specifically addresses the amount of staff based on the census." The statement was signed by the current administrator and dated 5-26-21. In an interview on 5/26/2021 at 11:00 A.M. the facility Administrator (ADM) stated that the facility had none of the previous staff currently working in the facility that were working in September 2020 or March 2020. ADM stated that the previous administrator and the previous Director of Nursing (DON) left the facility suddenly and never returned. The current ADM stated that he took over as the new administrator in March 2021. The ADM stated that the alleged events of lack of staff in September 2020 may have been a possibility, and were prior to his employment, but he would have to investigate. The Covid -19 Pandemic caused a no visitors policy and caused numerous staff and residents to become ill. The facility utilized outside agencies for staffing during the Covid-19 pandemic in 2020. In an interview on 5/26/21 at 11:00 A.M. with the current DON revealed that she had only been working at the facility since March 2021. DON stated that she had no knowledge of staffing	M 225	Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Nurse Aides (C N A) 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Briar Hill Nursing and Rehab (BH) advertises vacant positions with intent to fill through Indeed.com. The staff development (SD) nurse will review nursing applications and identify those that possess the required qualifications and credentials for the vacant position. The administrator and the SD nurse will meet weekly beginning July 1, 2021. The vacant positions, applicants, and progression towards hiring qualified candidates will be discussed. Beginning 7/1/21 the. The number of staff hours will be compared to the census to ensure that the require 2.8 resident hours are met for each 24-hour day for the rest of the week. If the schedule direct care hours fall short for a future day, the DON will reassign staff or shifts in to ensure that the required 2.8 resident direct care hours are met. The DON will reassign administrator nurse staff (such as, SD nurse, minimum data sets nurse and/or medical records nurse) in the that direct care staff are unable to report to work and to ensure that the required 2.8 resident care hours are met. On 6-22-21 the Quality Assurance and Performance Improvement (QAPI) Committee discussed the need to review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 3 shortages in March 2020 and September 2020. DON stated that she would have to try and look through the records that were left by the previous staff, but was doubtful that documentation would be available since there was no staff left working at the facility that were working in March 2020 and September 2020. DON stated that most of the past staff had been replaced with completely different staff since she had arrived at the facility in March 2021. DON stated that none of previous facility staff was currently working at the facility. Interview on 5/26/2021 at 12:30 P.M. with the family member of Resident #1 revealed that she felt the facility was short staffed and she felt that the facility was unable to employ enough staff to better care for residents because the pay was so low and the work was too hard. She stated that the incident that happened with resident #1 had happened prior to the Covid-19 pandemic and that it was in January 2020 prior to resident #1's death at the hospital February 2020. She stated that her father was a very sick man and he was paralyzed and was totally dependent upon others for all of his needs. She stated that her father was transferred to the hospital in February 2020 from the nursing home and that her father died in the hospital due to his poor health not because of the facility bumped his head and/or were short of staff. Interview on 05/26/21 at 12:45 P.M. with the Resident Representative (RR) for Resident #1, she stated that she did not feel that the facility had enough staff working at the facility. Record review of the facility Grievance Logs maintained by the social worker contained a written report for Resident #2 which alleged that on 05/26/2020 the Resident asked the staff to be	M 225	direct care staffing schedules daily and ensure that the required 2.8 direct care hours would be prior to each day based on the census. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The administrator and the SD nurse will monitor the direct care daily work schedule to ensure the 2.8 direct care hours are met daily. Dates noted where the required staff hours are not met will be identified and corrected in advance beginning 7-1-21. The SD nurse will report to the bimonthly QAPI Committee the vacant positions, progress towards filling the positions, the direct care staffing hours for the reporting months, beginning 7-5-21 for 6 months. The QAPI Committee will assess the effectiveness of the corrective plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 4	M 225		

changed and the staff stated "I have thirty other people and you will have to wait your turn" and wasn't changed for hours. The grievance report for Resident #2 documented: Summary Statement of Grievance: "Family stated that the resident went without getting changed for hours. The staff told the resident to wait her turn via family member." Steps Taken to Investigate the Grievance: "Talked to staff -Inservice Staff" Summary of Pertinent Findings or Conclusions: "No staff admitted to saying it. Inserviced staff on effective communication and answering residents request in a timely manner." Decision: "Grievance was confirmed. (Describe resolution.) Inservice staff on effective communication." The record review did not reveal the names of any staff involved with the incident of 05/26/2020.

Interview on 05/26/21 at 3:45 P.M. the current ADM revealed that the staffing grids for September 2020 did document that the facility did not meet the 2.8 staffing requirements for all 30 days of September 2020. The ADM did confirm that he was not employed at the facility in September 2020. The ADM stated that on 09/03/2021 the former facility administrator, at that time, had walked out of the facility and did not return to work. ADM stated that during the Covid 19 pandemic the facility had a hard time staffing the facility due to illness of staff and due to lack of agency employees to back up the call ins. The ADM stated that there were two days in March 2020 that the 2.8 staffing ratio was not met on 3/30/2020 and 3/31/2020. ADM stated that there were no staff working in the facility currently that were working in the facility in March of 2020 or September 2020. All current staff working in the facility have been newly employed since December 2020. ADM has no knowledge of any negative outcomes as a result of staffing ratio

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 5 numbers not being met for two days in March 2020 and/or for the several days in September 2020. Interview on 05/26/2021 at 4:30 PM, with the facility Licensed Master Social Worker (LMSW), revealed that she was newly employed in December 2020. LMSW confirmed that she was responsible for the grievances and displayed a large book of reported grievances that she was responsible for maintaining. The LMSW confirmed that when she first came to work in December 2020 that the facility had a shortage of staff on the 7:00 A.M. -3:00 P.M. shift. LMSW stated that the non-nursing staff were all pitching in to assist with residents and to help meet their needs in the absence of nursing staff. Record review of the Staffing Grid for September 2020 revealed that the facility did not maintain the required staffing numbers of 2.8 staff ratio for 12 days in September 2020. The staffing ratios were lower than the required 2.8 for 12 days in September 2020. The dates of September 1, 2, 3, 5, 6, 7, 10, 11, 12, 15, 26, & 27, had lower staffing ratios than 2.8 and were documented on the staffing grid and signed by the current ADM on 5/26/21 as correct for those dates. March 2020 had two dates that the staffing ratio was less than 2.8 and that was March 30 & 31. The current ADM submitted the staffing grids and he signed the grids as being correct. Interview on 05/26/2021 at 5:00 P.M. with Minimum Data Set (MDS) nurse revealed that he worked a lot of nights and over time during the pandemic of 2020 and stated that the facility did have some shortages of staff during the pandemic of 2020.	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BH	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 6 Observation and Interview on 05/26/21 at 4:45 P.M. with resident #5, revealed that she felt that there was a need, at times, for more staff to assist residents with their care needs. She stated that she is not in need of staff assistance for her care because she is independent and does not need staff assistance for her care. But, she stated, some of the other residents needed more assistance. Resident #5 stated that she is the current resident council president. Record review of resident #5's medical record MDS Coordinator Facility Brief Interview of Mental Status (BIMS) Report revealed that she had a BIMS score of 15, which indicated that she was cognitively intact. Record review of the Face Sheet revealed that resident #5 was admitted to the facility on 04/22/2016. Resident #5 had medical diagnoses of Chronic obstructive pulmonary disease with (acute) exacerbation; Acute and chronic respiratory failure with hypercapnia; Type 2 diabetes; among other diagnoses. The ADM signed and dated on facility letterhead that the facility had no staffing policies and procedures. As per the documented staffing grids that were submitted by the facility for March 2020 and September 2020, the facility did not maintain the required staffing ratios of 2.8.	M 225		