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 08/15/2024

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 The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), at the facility from 08/13/24 through 8/15/24. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated a Facility Reported Incident (FRI) CI MS #25862 related to resident abuse and dignity and CI MS #25884 related to employee on resident abuse and dignity and cited M500 and M640 related to these CI's. CI MS #25621 was also a FRI and was investigated for accidents related to a fall with injury and CI MS#26867 was investigated related to physical abuse related to bumping a residents head. There were no deficient practices cited related to these CI's. The SA cited M475, M815, and M855 related to the recertification survey.	M 000		
M 475	45.16.6 Employee Testing for Tuberculosis Employee Testing for Tuberculosis 1. Each employee, upon employment of a licensed entity and prior to contact with any patient/resident, shall be evaluated for tuberculosis by one of the following methods: a. IGRA (blood test) and an evaluation of the individual for signs and symptoms of tuberculosis by medical personnel; or b. A two-step Mantoux tuberculin skin test administered and read by a licensed medical/nursing person certified in the techniques of tuberculin testing and an evaluation of the individual for signs and symptoms of tuberculosis by a licensed Physician, Physician ' s Assistant,	M 475		9/25/24

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 08/15/2024

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 475	Continued From page 1 Nurse Practitioner or a Registered Nurse. 2. The IGRA/Mantoux testing and the evaluation of signs/symptoms may be administered/conducted on the date of hire or administered/read no more than 30 days prior to the individual ' s date of hire; however, the individual must not be allowed contact with a patient or work in areas of the facility where patients have access until receipt of the results of the IGRA/assessment or at least the first of the two-step Mantoux test has been administered,/read and assessment for signs and symptoms completed. 3. If the Mantoux test is administered, results must be documented in millimeters. Documentation of the IGRA/TB skin test results and assessment must be documented in accordance with accepted standards of medical/nursing practice and must be placed in the individual ' s personnel file no later than 7 days of the individual ' s date of employment. If an IGRA is performed, results and quanitive values must be documented. 4. Any employee noted to have a newly positive IGRA, a newly positive Mantoux skin test or signs/symptoms indicative of tuberculin disease (TB) that last longer than three weeks (regardless of the size of the skin test or results of the IGRA), shall have a chest x-ray interpreted by a board certified Radiologist and be evaluated for active tuberculosis by a licensed physician within 72 hours. The employee shall not be allowed to work in any area where residents have routine access until evaluated by a physician/nurse practitioner/physician assistant and approved to return. Exceptions to this requirement may be	M 475		

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 08/15/2024

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 475	Continued From page 2	M 475		

made if the employee is asymptomatic and;

a. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the Mississippi State Department of Health (MSDH) Tuberculosis Program for tuberculosis infection, or

b. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the MSDH Tuberculosis Program; or

c. The individual has a documented previous significant tuberculin skin reaction or IGRA reaction.

4. For individuals noted to have a previous positive to either Mantoux testing or the IGRA, annual re-evaluation for the signs and symptoms must be conducted and must be maintained as part of the employee ' s annual health screening. A follow-up annual chest x-ray is NOT required unless symptoms of active tuberculosis develop.

5. If using the Mantoux method, employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees ' personal record within fourteen (14) days of employment.

6. The IGRA or the two-step protocol is to be used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that

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 08/15/2024

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 475	Continued From page 3 the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work in areas of the facility to which residents have routine access prior to reading the skin test, completing a signs and symptoms assessment and documenting the results and findings. 7. All staff noted as negative per the IGRA blood test or who do not have a significant Mantoux tuberculin skin test reaction (reaction of less than 5 millimeters in size) shall be retested annually within thirty (30) days of the anniversary of their last IGRA or Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner/physician assistant for treatment of latent tuberculin infection. This Statute is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to follow-up with annual Tuberculosis (TB) screening for (11) of 74 TB assessment forms reviewed. Findings include: A review of this facility's policy, "Tuberculosis Skin Testing Employee and Resident", revealed, "All employees ...will be screened for tuberculosis ...Employees ...must be tested prior to employment and annually thereafter..."	M 475	1. All employees of the building were given a TB Skin Test by Registered Nurse/Infection Control Preventist and each employee had recieved their skin tests by 8/21/2024. Also, the TB Skin Test Identifying Binder was brought up to date by placing the new readings in the binder on 8/21/2024. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all	

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 08/15/2024

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 475	Continued From page 4 On 08/15/2024 at 12:13 PM an interview with the Director of Nursing (DON) confirmed the outdated TB signs and symptoms for 11 active staff of the facility. The DON confirmed that the responsibility for maintaining up to date TB records fall on her as the DON and the Assistant Director of Nursing (ADON). The DON reported the importance of having up-to-date TB skin tests is to minimize the risk to residents. The DON stated her expectation going forward is that the TB skin tests and/or signs and symptoms will be done yearly. On 08/15/2024 at 12:20 PM, an interview with the Administrator acknowledged the outdated TB signs and symptoms records. The Administrator reported the upkeep of the TB records is the responsibility of the DON and the ADON. The Administrator confirmed the benefit of having up to date TB record is to maintain infection control. The Administrator stated that his expectation is the TB records will be maintained and kept up to date.	M 475	residents or only certain residents: The Quality Assurance Committee determined this deficiency is a practice not following Infection Control Measures, therefore this deficient practice has the potential to affect all residents within the facility. 3. The TB Skin Test Binder will be reviewed by the Director of Nursing Services and the Licensed Nursing Home Administrator weekly for 6 months beginning 8/19/2024 for accuracy. No employee will be allowed on the floor or to participate in the facility orientation process without the placing of a TB Skin Test. The Human Resources Manager will review the TB Binder Monthly to ensure all newly hired and current employees have the TB Skin Test performed. 4. The Licensed Nursing Home Administrator will bring his audit records of the TB Binder and the Director of Nursing Services will bring her audit records of the TB Binder to the Quality Assurance Committee beginning 9/25/2024 monthly for 6 months for review and attaining substantial compliance. If substantial compliance has been met within the 6 months, the Licensed Nursing Home Adminstrator and the Director of Nursing Services will begin to bring the audit records of the TB Book quarterly to maintain such substantial compliance.	
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident	M 500		9/25/24

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 08/15/2024

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 500	Continued From page 5 admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical	M 500		

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 08/15/2024

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 500	Continued From page 6 reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for	M 500		

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 08/15/2024

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 500	Continued From page 7 restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents,	M 500		

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 08/15/2024

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 500	Continued From page 8 unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident was free from exploitation for one (1) of 16 sampled residents. Resident #12. Findings Include: A review of the facility's policy, "Resident Rights," dated 2018, revealed: "1. Resident Rights. The resident has the right to a dignified existence, self-determination...5. Respect and Dignity. The resident has a right to be treated with respect and dignity..." A review of the facility's policy, "Abuse, Neglect and Exploitation," reviewed/revised 5/25/24, revealed: "Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and	M 500	1. Upon given the allegation of abuse and review of the video taken the Licensed Nursing Home Administrator notified the Following Authorities and Persons - a) The Mississippi Department of Health b) The Mississippi Attorney General's Office c) The Rankin County Sherriff's Office d) The Facility Medical Director e) The Resident's Responsible Party d) Local Hospice Administrator. Each of these entities were advised of the allegation of abuse. The employee you committed this deficient practice of abuse was terminated of her employment on July 15, 2024 at 2:00pm. The Licensed Nursing Home Administrator conducted interviews with Nursing Services Staff and Local Hospice Nursing Staff that were currently giving her care, to determine any witness of abuse, neglect, or misappropriation towards Residents #12. Each stated they had not witnessed	

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 08/15/2024

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 500	Continued From page 9 implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property ... Definitions: "Exploitation" means taking advantage of a resident for personal gain ..."Mistreatment" means inappropriate treatment or exploitation of a resident ... IV. Identification of Abuse, Neglect and Exploitation ... B. Possible indicators of abuse include, but are not limited to: 9. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status ..." A record review of the " Facesheet" revealed that the facility admitted Resident #12 to the facility on 10/20/2020. The resident had diagnoses that included Unspecified Dementia and Cognitive Communication Deficits.. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/12/24 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to participate in the interview. A record review of the facility's "Reportable Incident Form", dated 7/19/24, revealed on 7/15/24 at 8:45 AM, two (2) Certified Nurse Aides (CNAs) reported to the Administrator that CNA #1 had made a video in which she forcefully and manually transferred Resident #1 to a Geri (geriatric) chair from her bed. Resident #1's extremities and lower body were exposed during the video, but her private lower body parts could not be seen. Upon receiving the information, the Administrator reported the incident to the state agency, AGO's office, local police, the Resident	M 500	any type of abuse, neglect, or misappropriation towards Resident #12. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or only Resident #12. It was determined by The Quality Assurance Committee by record review, care plans, and documentation that all residents have the potential to be affected by this deficient practice. 3. An Abuse, Neglect, or Misappropriation In-Service was conducted on July 16, 2024 by the Licensed Nursing Home Administrator. All Nursing Home staff will re-sign and give acknowledgement of the Facility's Abuse, Neglect, and Misappropriation Policy by 9/25/2024. The Director of Nursing Services and the Licensed Facility Administrator will make weekly rounds beginning 9/9/2024 interviewing residents for any signs of abuse, neglect, or misappropriation for 2 months and then bi-monthly. All of these documentations will be brought to the Quality Assurance Committee for review beginning 9/25/2024. 4. Monthly Abuse, Neglect, and Misappropriation In-Services will be conducted by the Licensed Nursing Home Administrator and the Director of Nursing Services and/or the Assistant Director of Nursing Services for 6 months beginning 8/30/24. For these 6 months, these in-services will be brought to the Quality Assurance Committee for review or until such compliance has been determined to	

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 08/15/2024

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 500	Continued From page 10 Representative (RR), the Medical Director, and the resident's Hospice agency. At 1:05 PM on 8/13/24, during an interview, CNA #2 stated she did not know CNA #1 personally because their work schedules differed. She reported that a former coworker called her on the evening of 7/14/24 and told her to watch a live video on social media involving CNA #1 and Resident #12. CNA #2 logged onto the social media account and saw the live video of CNA #1 in the resident's room dancing. She observed CNA #1 put the Geri (Geriatric) chair in front of the resident's bed and then grab the resident under the arms and manually transferred her to the Geri chair. CNA #2 stated that the transfer was unsafe because the resident should have been lifted by two people. She recalled that people watching the video made comments praising CNA #1 and called her "CNA of the year," and CNA #1 showed her thanks by clapping, which made it appear that she enjoyed the attention. The resident stayed seated in the chair, and while her body was visible in the background, she was not naked. The video ended when CNA #1 looked toward the door, as if she thought someone was coming into the room. CNA #2 stated that she reported the video that she had watched to the Administrator on the morning of 7/15/24. On 8/13/24 at 1:16 PM during an observation of the social media video footage, which was filmed live and posted online, CNA #1, who posted the video using another name, was observed lifting Resident #12 from her bed into the Geri chair. The resident's thighs, legs, and feet were visible to viewers, but her face was not disclosed. Once Resident #12 was seated in her geriatric chair, CNA #1 turned to the camera, clapped her hands,	M 500	have been met beginning 8/30/2024. If compliance has been determined by the Quality Assurance Committee Abuse, Neglect, and Misappropriation In-Services will be brought to the Quality Assurance quarterly for review and continued compliance. A Quality Assurance Performance Improvement Plan will be initiated by 9/25/2024 to maintain implemented actions.	

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 08/15/2024

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 500	Continued From page 11	M 500		

smiled, and shook her buttocks while the audience praised her. CNA #1 then moved in the video, exposing the resident's face and bottom half of her body. As she continued communicating with the audience, CNA #1 waved her hand in front of her face, indicating that Resident #12 had an odor coming from her body. The audience responded with obscenities, and CNA #1 laughed. In response to viewer comments, CNA #1 said, "Lord forgive me," and the video ended. The live video lasted one minute and seven seconds.

On 8/13/24 at 2:36 PM, during an interview with the Administrator, he reported that a 7/15/24 at approximately 8:45 AM, CNA #2 informed him of a video posting from a current CNA on social media. He stated that he watched the video that morning. He further stated that he personally conducted the investigation, as the current Director of Nurses (DON) was not a part of the investigation. He continued by saying that CNA #1 was scheduled to come in that afternoon to work, so he let her come in and that is when he told her that he had seen the video and that he was terminating her employment at the facility and that she needed to leave the building.

At 8:32 AM on 8/15/24, during a telephone interview with CNA #1, she revealed she had been a licensed CNA for about three years and had worked at the facility where Resident #12 lives for about two months. She vehemently denied appearing in the social media video with Resident #12 in the background. She claimed the Administrator called her into the building and told her about a video, but he never allowed her to watch it to ensure it was her. In the interview, she explained that she would not do such a thing because she knew it was wrong to video

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 08/15/2024

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 500	Continued From page 12 residents. Since CNA #1 denied it was her in the video, she was asked to explain why it would be wrong for residents to be posted on social media by any staff in general. CNA#1 said it would violate the resident's rights and patient confidentiality. She said it would be wrong since she understood that to video a resident, you must first have the resident's or the responsible party's consent first. At 8:54 AM on 8/15/24, in a follow-up interview with CNA #1, she was informed that according to the picture of the driver's license in her personnel file, it was her on the live social media. CNA #1 got quiet and responded, "I did not do a video on that particular social media site live. I just want to make sure you do not put that on your paper." On 8/15/24 at 11:40 AM, during an interview with Resident #12's family, the family member stated that the resident was very private and would not have wanted or allowed someone to make such a video of her. He stated that she would have been offended.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on observation, interview, record review, and policy review the facility failed to ensure a two-person transfer, as determined by the	M 640	1. The RN Supervisor/Infection Preventionist assessed Resident #12 for injury,brusing,skin tears. No signs of pain,	9/25/24

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 08/15/2024

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 640	Continued From page 13 comprehensive care plan, during a transfer from the resident's bed to the geriatric chair, which created a risk for more than minimal harm, for one (1) of sixteen (16 sampled residents. Resident # 12. Findings Include: A review of the facility policy titled "Modified Lifting Policy", no date, reveals, "Facility will provide a safe work environment for patient care areas by providing and requiring the use of safety materials, equipment and training designed to prevent personnel and patient injury...It is crucial that health care professionals practice safe lifting, transporting..." At 1:05 p.m. on August 13, 2024, as Certified Nursing Aide (CNA) #2 recapped what she saw in the social media video, she specifically pointed out that she saw CNA #1 put the geriatric chair in front of the resident's bed. She remembers seeing CNA #1 grab the resident under the arms and move her to the geriatric chair by hand. She stated the transfer was unsafe because the resident should have been transferred by two people, as the resident was an extensive two person assist for transfer. On 8/13/24 at 1:16 p.m., during an observation of the social media video footage, which was filmed live and posted online, CNA #1, lifted the resident without assistance and transferred her to a geriatric chair. On 8/13/24 at 2:36 PM, during an interview with the Administrator, he confirmed that on 7/15/24 at approximately 8:45 AM, a CNA informed him of a video posting from a current CNA on social media. He stated that he watched the video that	M 640	injury, or bruising was found. No actual harm occurred. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or certain residents. It is the determination of the Quality Assurance Committee through the review of Medical Record, Care Plans, and Documentation that all Residents have the potential to be affected by this deficient practice. 3. An all Nursing Service Staff Meeting(Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants)will be held on 9/17/2024 for Lift Training to be conducted by the distributor of the facility lifts and it components. Also, the Medical Records Licensed Practical Nurse and the Registered Nurse Minimum Data Set Case Manager will perform a 100% Care Plan Audit to ensure proper lift assessments are included in each Resident's Plan of Care and will be completed by 9/25/2024. Any additions or adjustments found to be needed will be made by the Medical Records Nurse and/or the Registered Nurse Minimum Data Set Case Manager and will be completed by 9/25/2024. The Director of Nursing Services, the Assistant Director of Nursing Services, or the Registered Nurse Supervisor will monitor Resident #12 when being transfered from the bed to the geriatric chair weekly for 3 months and then quarterly to ensure the safety of Resident #12 during transfer. These audit documentations will be brought to the	

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 08/15/2024

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 640	Continued From page 14 morning. He continued by saying that CNA #1 was scheduled to come in that afternoon to work, so he let her come in he explained to her that he had seen the video that she had posted that involved the care of Resident #12. At time, her reported that he told CNA #1 that he was terminating her employment and that she needed to leave the building. On 8/14/24 at 9:28 AM, in an interview with Minimum Data Set (MDS) Nurse, she confirmed that for transfers, Resident #12 is care planned as an extensive two person assist. She stated this was put into place to ensure the safety of the resident to prevent the resident from falling and having all types of injuries. She adds that the CNAs can use the kiosk (interactive computer terminal) on the wall to identify the plan of care for residents. Therefore, with this resident they should never attempt to lift or transfer the resident by themselves. On 8/14/24 at 2:01 PM in an interview with CNA #3, she confirms that Resident #12 is one her residents that she is assigned to from time-to-time. She explains that this resident is a total body lift and requires an extensive two person transfer when moveing her out of the be. A record review of the admission record reveals Resident #12 was admitted on 10/20/20 by the facility. Her diagnosis includes Cognitive Communication Deficit and Unspecified Dementia. A record review of the quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/12/24 reveals a Brief Interview Mental Status (BIMS) score of 99, which indicated that the resident was unable to participate in the	M 640	Quality Assurance Committee beginning 9/25/2024 for review and further recommendation if the Quality Assurance Committee deems necessary. 4. The Director of Nursing Services and the Assistant Director of Nursing Services will make weekly audits for 2 months beginning 8/19/2024 and will continue until 10/15/2024 for the proper use of mechanical lifts and for 2 person assist beginning on 8/19/2024. These audit records will be brought to the Quality Assurance Committee for 2 months until such time consistent substantial compliance has been met beginning on 9/25/2024. After 2 months and compliance is met, the Director of Nursing Services and the Assistant Director of Nursing Services will make quarterly audits for the use of proper mechanical lift procedure and 2 person assist. These audit records will be brought to the Quality Assurance Committee for review and compliance.	

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 08/15/2024

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 640	Continued From page 15 interview.	M 640		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, interviews, and facility policy review, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to unlabeled foods, foods without identified dates, exposed foods, and overly ripe produce for one (1) of two (2) kitchen observations. Findings Include: A review of the facility's policy, "Storage of Refrigerated Food", revised 10/17, revealed, "The facility ensures the quality and safety and sanitation of refrigerated foods through accepted storage practices. Procedure ...4. No food is left uncovered. 5. All opened foods are labeled with common name of food, date stored, and use-by date ..." On 08/13/24 at 9:19 AM, during an observation of the kitchen and interview with the Certified Dietary Manager (CDM), Refrigerator #1 had nine (9) overly ripe tomatoes containing white biological growth on each tomato. There was (1) unopened bag of salad mix with a facility received sticker of 8/7/24, with no manufacturer's date,	M 815	1.The overly ripe produce, outdated milk, and unlabeled food items in the kitchen, along with the exposed shrimp and the unopened bag of salad was disguarded into the garbage on 8/13/2024. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or only certain residents. The Quality Assurance Committee agreed with this being an unsanitary practice and that all residents have the potential of being affected by this deficient practice. 3. An In-Service was held by the Licensed Nursing Home Administrator and the Certified Dietary Manager will all kitchen staff on 8/20/2024 pertaining to Preventing Foodborne Illnesses. On 8/19/2024 the Registered Dietician conducted an In-Service with the Certified Dietary Manager and all kitchen staff pertaining to Food Storage, Sanitary Conditions, and Dietary Policies. 4. A Bi-Weekly Audit for verifying proper food storage, sanitary conditions and	9/25/24

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 08/15/2024

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 815	Continued From page 16 and a brown discolored liquid inside the bag. There was (1) opened block of cream cheese inside a plastic food storage bag with a written-on date of 6/30/24. The CDM explained that this was the date it came in and most likely the date it was opened. Additionally, there was (1) plastic storage bag of sliced ham with a handwritten date of 7/28, (1) plastic storage bag of bologna dated 8/12/24, (1) plastic storage bag of bologna with a date of 8/7/24, and (1) plastic storage bag of bologna dated 7/8/24. The CDM stated these were the dates the sliced ham and bologna were opened and placed in the bags. An observation of Refrigerator #3 revealed four (4) eight (8) ounce containers of chocolate milk wrapped in plastic wrap with a manufacturer's date of "Aug 11" and a "received-on" date of 7/31." An observation of the freezer revealed (1) bag of shrimp that was opened, and the shrimp was exposed. On 08/13/24 at 01:00 PM, during an interview, the CDM acknowledged the overly ripe produce, outdated milk, and unlabeled food items in the kitchen. The CDM stated it was his responsibility to check for outdated foods and to insure proper labeling. He expressed that food should be checked daily and confirmed that he in-serviced the staff monthly on food safety. On 08/15/24 at 12:20 PM, an interview with the Administrator revealed he was aware of the findings during the kitchen observations regarding unlabeled and out of date food items, as well as expired and exposed foods. The Administrator stated he expected the kitchen staff to monitor the foods daily for expired items and to inspect the produce daily.	M 815	following dietary policies will be performed by the Certified Dietary Manager beginning 8/19/2024 for 3 months. Audit records will be brought to the Quality Assurance Committee monthly beginning 9/25/2024 for those 3 months to determine substantial compliance has been attained. After such substantial compliance has been met, the Bi-Weekly audits perfomed by the Certified Dietary Manager will be brought to the Quality Assurance Committee quartrly to maintain such substantial compliance.	

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 08/15/2024

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 855	Continued From page 17	M 855		
M 855	45.30.7 Food Preparation Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to serve therapeutic portion sizes of foods as planned per the facility's menu for one (1) of seven (7) food items requiring specific portions on the lunch meal tray line. Resident #40 Findings Include: A review of the facility's policy, "Tray Assembly", revised 6/17, revealed, " ...Prepared foods are portioned and assembled for individual meals in the food and nutrition services department. Procedure ...6. Menu items and equipment are positioned in reach of the food service employees. These items include ...c. Serving utensils as specified on the menu and equipment needed for correct portions ...10. Portions are ...weighed on portion scales ..." A record review of the facility's "Menu Guide Report" for Spring/Summer 2024 revealed the following portion sizes to be served at lunch: 3 ounces of country meatloaf, 1/3 cup of mashed potatoes,1-ounce brown gravy, 1/3 cup of buttered green peas, one (1) fresh baked roll, one (1) piece of confetti cake with icing, and one (1) cup of iced tea.	M 855	1. An In-Service was given by the Certified Dietary Manager to the Morning Cook on 8/14/2024 explaining how the Menu's are to be followed, explaining how portion sizes are to be weighed on the portion scale, explaining if the Menu states a specific weight it must be weighed on the portion scale, and explaining that she and all cooks must use portion control. 2. On 8/16/2024, the Quality Assurance Committee met to review the deficiency and determine if it will potentially affect all residents or only certain residents. Through Medical Record, Care Plan, and Documentation review, the Quality Assurance Committee determined that all residents have the potential to be affected by this deficient practice. 3. On 8/19/2024 the Registered Dietician held an In-service with all Kitchen Staff, including the Certified Dietary Manager concerning the Knowledge and Understanding of proper utensils for serving sizes of the Dietary Menus. 4. A Bi-Weekly Audit for verifying proper portion sizes and the use of proper utensils and following the dietary menus	9/25/24

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 08/15/2024

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 855	Continued From page 18 On 08/13/24 at 10:51 AM, during an interview, Resident #40 complained her meals had inconsistent portion sizes and stated she had mentioned this concern to the facility staff. On 08/13/24 at 12:35 PM, an observation of two (2) sampled meal trays with the Certified Dietary Manager (CDM) revealed the meal consisted of meatloaf, mashed potatoes, green peas, roll, cake and tea. The portion sizes for the meatloaf were notably different. On 08/13/24 at 12:50 PM, during an interview, Dietary Staff #1 acknowledged that she sliced the meatloaf freehand, resulting in each slice being visibly different in size. The cook confirmed that a serving of meatloaf should be 3 ounces and reported that the facility had not provided any means for her to measure a serving of meatloaf. On 08/13/24 at 1:00 PM, during an interview with the Certified Dietary Manager (CDM), he stated that he was unaware the meatloaf was not evenly sliced. The CDM confirmed that a serving of meatloaf should be 3 ounces and reported that the facility had a scale available to measure portions of meatloaf. However, he confirmed that no scale was present during the serving of that day's meatloaf. On 08/15/24 at 10:34 AM, during an interview with the Administrator, it was confirmed that he had already been made aware of the inconsistent portions of food served during lunch on 08/13/24. The Administrator stated that he expected the dietary staff to follow the portion sizes identified on the menu. A record review of the Quarterly Minimum Data	M 855	will be performed by the Certified Dietary Manager for 3 months beginning 8/19/2024. Audit records will be brought to the Quality Assurance Committee monthly beginning 9/25/2024 for 3 months to determine substantial compliance has been attained. After such substantial compliance has been met, the Bi-Weekly audits perfomed by the Certified Dietary manager will be brought to the Quality Assurance Committee quartrly to maintain such substantial compliance.	

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 08/15/2024

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 855	Continued From page 19 Set (MDS) with an Assessment Reference Date (ARD) of 06/01/2024 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Record review of the "Care Profile" revealed a physician order that Resident #40 was to receive a "Regular diet, Regular texture, and Large portions.	M 855		