

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Complaint Investigation (CI) MS #28147, CI MS # 28148, CI MS# 28166, MS CI # 28348 and CI MS# 28536 at the facility from 4/7/25 to 4/9/25. CI MS # 28147 was investigated regarding quality of care, neglect, abuse, and quality of treatment. CI MS #28148 was investigated regarding elopement, staffing, feeding assistance, and dignity. CI MS # 28166 was investigated regarding call lights, infection control, turning and reposition and bowel and bladder. CI MS #28348 was investigated regarding neglect and bowel and bladder. CI MS# 28536 was investigated regarding accidents and hazards. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 related to CI MS#28536..	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident 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	M 500		4/30/25

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/22/25

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 1 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 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	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 2 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 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	M 500			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 3 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, 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	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on interview, record review, and policy review, the facility failed to ensure the resident's right to be free from neglect when staff failed to both assist during use of a full body lift to transfer a resident from bed to the geriatric chair, which resulted in the resident being transferred to the hospital with injuries for one (1) of (30) residents who are assessed to use a full body lift. Resident #1 Findings include: A review of the facility policy titled "Modified Lifting Policy," updated 2/3/23, 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...Procedure.1. Staff will follow the documented lifting protocol deemed appropriate for each resident." A review of the facility policy titled "Total Lift Vanderlift II," updated 2/3/23, revealed, "...Responsibility... Two people are required to operate the Total Lift." On 4/9/25 at 10:04 AM, the State Agency (SA) conducted a phone interview with Certified Nursing Assistant (CNA) #1. During the interview, she recalled that she was asked by CNA #2 to "spot her" with a resident transfer to the geri-chair on 4/7/25. Upon entering Resident #1's room, she noted the resident was already attached to the total body lift. She further stated that facility policy	M 500	1. The Licensed Facility Administrator and the Director of Nursing Services inspected the total lift involved in the incident and inspected the sling involved in the incident to determine if any malfunctions were noted with the lift or if any problems were found with sling. No malfunctions were found with the lift and no abnormalities were noted with the sling. The Licensed Facility Administrator and the Director of Nursing Services conducted a re-enactment of the incident to determine if any malfunctions could be noted with the lift or sling. No malfunctions were noted during the re-enactment. The lift used during the incident was then taken off of the floor and placed in storage until further inspection for use could be made by the manufacturer at a later date. An all staff Abuse and Neglect In-Service was started by the Director of Nursing Services pertaining to Resident Neglect on 4-07-2025. The manufacturer's inspection was performed on 4-8-2025 and noted no malfunctions and the lift was in proper working function. The 2 Certified Nursing Assistants involved in the incident resulting in bodily harm to the resident were placed on suspension pending further investigation. 2. The Facility has determined that 30 residents assessed for the use of a total lift and 2 residents assessed for the use of a sit to stand lift have the potential to be affected by this deficient practice.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 allows CNAs to attach a resident to the lift independently; however, the actual transfer necessitates a second person present in the room only. Therefore, as CNA #2 operated the lift, she turned her back to them to retrieve the geri-chair. At that point, she heard a loud pop followed by CNA #2's exclamation of, "Oh my god, she is sliding!" CNA #1 stated that she initially suspected a sling malfunction but observed it remained intact. Upon turning, she saw the resident's head resting at the foot end of the sling while her feet remained elevated within it, and there was blood near the resident's head. She reported that CNA #2 instructed her to get Licensed Practical Nurse (LPN) #1, who then directed her to notify the Director of Nursing (DON). Subsequently, she lowered the lift to remove the sling from under the resident's shoulders, with nurses assisting in its complete removal. She noted blood on CNA #2's hand, which was supporting the resident's head. Initially, the resident was unresponsive but later began yelling for help and continued to do so until paramedics arrived. She believed all actions taken were consistent with her training; however, CNA #2 reported that the resident began sliding after pushing back against the lift with her foot. On 4/9/25 at 10:38 AM, in a phone interview with CNA #2, stated that she entered Resident # 1's room to assist with dressing for therapy on 4/7/25. She reported placing the sling under the resident before CNA #1 entered the room, noting a dot on the lift that indicates the sling size (small, medium, or large). A medium sling was used. She then lowered the lift to the resident, attached the four hooks, and began to move the resident backward. She confirmed the lift legs were open and all four sling hooks were attached. While waiting for CNA #1 to position the geri-chair, she	M 500	3. On 4-7-2025 through 4-8-2025 the Assistant Director of Nursing Services and the Certified Nursing Assistant/Van Driver/Lift Instructor performed lift technique in-services with all Nursing Services covering all three shifts. These in-services pertain to re-instructing Nursing Services on how to use lifts properly and how to place a resident properly into a sling properly before lifting a resident or transferring a resident via use of a total lift or sit to stand lift. On 4-8-2025, a representative of Storm Medical Supply (the facility's supplier of total lifts and sit to stand lifts) performed an in-service with All Nursing Management instructing them on the proper lift techniques for the total and the sit to stand lift. This in-service also included the proper technique of placing a sling onto a resident prior to being placed on a lift. Each of the Nursing Managers have signed in-services and these in-services are in a binder in the Director of Nursing Services Office. Further in-services will be conducted with all Nursing Services and concluded by 4-28-2025. The Director of Nursing Services re-assessed all residents for the proper lift type and it was concluded that 30 residents are assessed for the total lift and 2 residents for the sit to stand lift. The re-assessments were performed on 4-9-2025. 4. The Director of Nursing Services, the Assistant Director of Nursing Services, the Registered Nursing Supervisor, and/or the Weekend Registered Nursing Supervisor will perform audits with the Certified Nursing Assistants, on all shifts, 5 times	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 heard two loud "boom" sounds. She stated the resident was pushing against the lift, subsequently slid, and she was unsuccessful in catching her. The resident's head struck the lift. She went to secure the resident's head with her hands as she observed bleeding. CNA #1, who by this time was standing beside her, was instructed to get help. CNA #2 stated she does not recall everyone who responded due to being in shock. She estimated the resident lost consciousness for approximately one minute before regaining it and beginning to scream for help. CNA #2 reassured the resident. She expressed that she was still processing the incident, as nothing similar had ever occurred. She indicated that the resident is designated as a two-person assist according to the facility kiosk. She understood this to mean that two CNAs must be present in the room before connecting the resident to the lift and denied connecting the resident prior to CNA #1's arrival. She suggested that the only potential for a different outcome could be if CNA #1 had been standing directly beside her to maybe help catch the resident before she slid out. She confirmed the sling did not break. She also stated that the Administrator had her perform a reenactment using the same sling, which showed no signs of damage. On 4/9/25 at 11:02 AM, in an interview with Lift Trainer, who conducts lift transfer training for CNAs, revealed the standard procedure for transferring a resident using the total body lift. While one CNA supports the resident's head with a hand on the lift, the second CNA guides the resident into the geri-chair. The Trainer emphasized that this is the method she uses for all CNA training and, based on her experience, considers it the safest approach to resident transfers, minimizing the risk of injury. She	M 500	per week, to insure proper lift techniques are being performed. The audits began on 4-14-2025 and will continue for 3 months and be brought monthly to the Quality Assurance Committee beginning 4-29-2025 for review. After this time period, and no deficient practices have been found, these audits will be brought to the Quality Assurance Committee for review every 6 months. The 2 Certified Nursing Assistants involved in the incident of neglecting the resident by not following facility policy and procedure and not following proper lift techniques were both terminated of their employment on 4-10-2025. 5. These corrective actions will be completed by the facility by 5-01-2025.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 reiterated the importance of both CNAs being strategically positioned at the lift throughout the transfer to ensure the resident's safety. During the interview on 4/9/25 at 11:27 AM, with Licensed Practical Nurse (LPN) #1, she explained to SA that "two-person assist" to her does require two CNAs positioned on the lift to attach the resident. She said once the resident is attached, one person maneuvers the lift while the other stands at the bottom with hands on, holding the resident in place to ensure the resident does not swing or sway and to keep them in a safe position during transfer. During the interview with the DON on 4/9/25 at 11:41 AM, she said a two-person assist using the total body lift means the CNAs must first enter the room together and collaboratively initiate the process. Working as a team, they then position the sling under the resident. During the lift, one CNA guides the equipment while both CNAs secure the lift straps on either side of the resident; one CNA stays with the resident, and the other operates the remote to elevate them. Once lifted, one CNA controls the remote while the other physically supports the resident as they are moved towards the chair. Both CNAs then carefully guide the resident into the chair, maintaining contact with the sling for safety, before jointly removing it. A record review of the "Admission Record" reveals the facility admitted Resident # 1 on 3/26/25 with diagnoses including Other Fracture of Left Lower Leg, Subsequent Encounter for Closed Fracture with Routine Healing. A record review of Resident # 1's Minimum Data Set (MDS) with Assessment Reference Date	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61BH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2025
NAME OF PROVIDER OR SUPPLIER BRIAR HILL REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 (ARD) of 4/1/25 reveals a Brief Interview for Mental Status (BIMS) score of five (5), indicating the resident could not fully participate in the interview. A record review of the "CT (Computed Tomography) Head" revealed "IMPRESSION: Interval scattered small volume bifrontal subarachnoid hemorrhage (bleeding in the space around the brain)." This was after the fall from the lift on 4/7/25. A record review of the Lift Transfer Eval (Evaluation) dated 3/26/25 revealed a two-person assist during transfer.	M 500		