STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255303	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with one (1) Complaint Investigation (CI MS # 2684586) at the facility from 1/20/2026 through 1/22/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F575, F658, and F677. There were no citations related to CI MS #2684586. The facility had a census of 54 and was licensed for 60 beds.	F0000		
F0575 SS = D	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to provide information for pertinent state agencies and advocacy	F0575		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0575 SS = D	Continued from page 1 groups, specifically the ombudsman for two (2) of three (3) days of survey. Findings include: Record review of facility grievance policy “Resident and Family Grievances” reviewed 2/24/19 revealed, "…Information on how to file a grievance or complaint will be available to the resident. Information may include but is not limited to… 7.a. The contact information of the grievance official with whom a grievance can be filed, including his or her name. business address (mailing and email) and business phone number. b. The contact information of independent entities with whom grievances may be filed, that is, the pertinent State Survey Agency and Local Long-Term Care Ombudsman program or protection and advocacy system. c. The time frame that a resident may reasonably expect completion of the review of the grievance and a written decision regarding his or her grievances…” On 1/20/26 at 3:05 PM, the State Agency (SA) toured the entire facility and observed there was no information posted displaying the ombudsman's contact information. On 1/21/26 at 9:50 AM, the State Agency (SA) toured the entire facility and observed there was no information posted displaying the ombudsman's contact information. On 01/21/2026 at 10:00 AM, in an interview with the Social Worker, she provided the SA with the ombudsman's information. She was asked if the facility had a sign displaying the ombudsman info and she said "yes". She was asked to take the state agency surveyor to the sign; she then took the SA to a hallway where she said the sign normally was but confirmed that no sign was there. Upon looking at the site, she concluded that the maintenance supervisor must have removed the sign to paint the wall and had not replaced it. She stated that the importance of keeping the ombudsman's information readily available via a sign for the residents is that residents will know how to contact the ombudsman with questions about their care or can go to them with concerns that they're not comfortable telling their staff members about and for information to get in touch with the state department of health for other concerns. On 1/21/2026 at 1:15 PM, during a Resident Council Meeting, the residents had concerns about the Ombudsman poster not being posted. Resident #1 stated the poster has been missing for over a month now. She stated they were painting the walls and did not replace the poster after they finished the painting the wall. On 1/22/26 at 8:20 AM, in an interview the Director of Nursing (DON), stated that the importance of ombudsman information being available to the residents is that they are able to contact them at any time to report their concerns about care and are able to report it to the state department of health. A record review of	F0575		

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F0575 SS = D	Continued from page 2 Resident #1's “Admission Record” revealed she was admitted on 5/21/21 with diagnoses that included hypothyroidism. A record review of Resident #1's Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 10/17/25 revealed a Brief Interview for Mental Status (BIMS) score of (15) which indicated the resident was cognitively intact.	F0575		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, and facility policy review the facility failed to ensure that services were provided in accordance with professional standards of practice and within staff scope of practice for one (1) of four (4) residents reviewed for enteral nutrition services. (Resident #6) Findings Include: Record review of the facility policy “Tube Feeding” undated revealed, “...Responsibility: All licensed Nursing personnel monitored by the Charge Nurse...” On 1/21/26 at 2:30 PM, an observation of Certified Nursing Assistant #2 (CNA) doing incontinent check on Resident #6 revealed she placed feeding pump on hold prior to checking the resident. CNA #2 left the room to obtain supplies for incontinent care. On 1/21/26 at 2:35 PM, during an interview with CNA #2 revealed "they let us place the pump on hold when do incontinent check on resident before we let the bed down flat." She stated when they finished, they were told to "turn the pump back on." She stated she watched the nurses operate pump and know how to put it on hold. On 1/21/26 at 2:56 PM, CNA #2 returned with supplies and CNA #3 to assist with turning. The feeding pump was still on hold and beeping. CNA #2 told CNA #3 to go get nurse to stop pump from beeping. Licensed Practical Nurse #1 (LPN) entered the room and placed pump back on	F0658		

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F0658 SS = D	Continued from page 3 hold. On 01/21/26 at 3:20 PM, during an interview with LPN #1 she confirmed when she entered Resident #6's room the feeding pump was already on hold. She stated she does not know who placed pump on hold. She stated the CNAs are not allowed to operate feeding pump. She stated CNAs are not trained to operate pumps and can cause the residents to be overfed, underfed or aspirated. She stated the peg feeding is ordered by the physician and considered a medication. On 1/21/26 at 3:28 PM, in an interview with CNA #2 she stated she turned the feeding pump off in error. She stated she should not have turned it off. She confirmed that she was practicing outside of her scope. On 01/22/26 at 1:45 PM, during an interview, the Director of Nursing (DON) stated that CNAs are not authorized to place feeding pumps on hold and that only licensed nurses are permitted to operate enteral feeding pumps. The DON stated CNAs are not trained to operate pumps and could cause residents to receive incorrect amounts of feeding or flushes. The DON stated her expectation is that CNAs notify licensed nursing staff to manage feeding pumps. A record review of the “Admission Record” revealed the resident was admitted on 3/11/25 with diagnoses including hemiplegia, unspecified, affecting the left nondominant side, and adult failure to thrive. A record review of the “Order Listing Report” revealed an order dated 7/25/25 for enteral nutrition via pump: Nutren 2.0 at 35 milliliter (mL) per hour providing 1980 calories daily, with 150 cubic centimeters (cc) water flushes every four (4) hours. A record review of the “Order Listing Report” revealed an order dated 7/25/25 for enteral nutrition via pump: Nutren 2.0 at 35 milliliter (mL) per hour providing 1980 calories daily, with 150 cubic centimeters (cc) water flushes every four (4) hours. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/25, revealed the resident was rarely understood.	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F0677		

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F0677 SS = D	Continued from page 4 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure a resident received necessary grooming assistance in accordance with her preferences for one (1) of (15) residents reviewed for Activities of Daily Living (ADLs). Resident #41 Findings include: A review of the facility policy, "Resident Rights," undated, revealed...5. Respect and dignity. The resident has the right to be treated with respect and dignity...." During an interview with Resident #41 on 1/20/26 at 11:20 AM, she stated that the staff do not shave under her arms. She reported that when she lived at home, she shaved under her arms every day or as often as needed. She added that if staff shaved under her arms at least once a week, she would be satisfied. During an observation on 1/20/26 at 11:21 AM, revealed Resident #41's underarm hair to be thick and approximately two and one-half (2.5) inches long. During an interview with Certified Nursing Assistant (CNA) #1 at 10:20 AM on 1/21/26, the CNA stated that shaving under the arms is part of the ADLs for residents. She explained that it is important to ensure this task is completed because it helps maintain residents' dignity and reflects what they would typically do at home. In a follow up interview at 10:34 AM, on 1/21/26 while assessing Resident #41, CNA #1 stated that the hair under Resident #41's arm appeared not to have been shaved in a while, adding, "It is really long and needs to be cut." On 1/21/26 at approximately 1:30 PM, during an interview the Director of Nursing (DON), explained that shaving under residents' arms is part of the ADLs provided by CNAs. She added that this task is performed for hygienic purposes and is part of maintaining residents' dignity. A record review of the "Admission Record" revealed the facility admitted the resident on 12/2/25 with diagnoses including Generalized Muscle Weakness and	F0677		

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F0677 SS = D	Continued from page 5 Other Lack of Coordination. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/26 revealed a Brief Interview Mental Score (BIMS) of 12 indicating the resident has moderate cognitive impairment.	F0677		