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 05/28/2026

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 a Complaint Investigation (CI MS #3021003) at the facility on 5/28/26 related to quality of care regarding call lights, grooming and activities of daily living, unsafe sharps containers and staffing. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid cited F558 and F921. The facility held a license for 60 beds, with a census of 58.	F0000		
F0558 SS = E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, facility policy review, and interviews, the facility failed to ensure residents were provided with reasonable accommodations to maintain a safe and functional environment by failing to keep call lights within physical reach for seven (7) of ten (10) sampled residents. Residents #4, #5, #6, #7, #8, #9, and #10. Findings Included: Record review of the facility policy “Call Light Policy”, revised January 12, 2015, revealed, “…1. All facility personnel must be aware of call lights at all times…11. Be sure all call lights are placed conveniently for the resident…” On 5/28/26 at 4:01 PM, observation revealed Resident #7 and Resident #10 did not have their call lights within their reach. On 5/28/26 at 4:05 PM, observation and interviews revealed that Resident #5 and Resident #8’s call	F0558		

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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F0558 SS = E	Continued from page 1 lights were out of reach and stuck (could not be pulled out easily) under Resident #5's bed. Observation revealed that Resident #5 had to get off her bed and it took Licensed Practical Nurse (LPN) #1 two minutes and moved the bed several times for LPN #1 to retrieve the call lights from under the resident's bed. During observation when asked if call lights should be in residents' reach, LPN #1 stated, "It's not like we don't know that". On 5/28/26 at 4:10 PM, observation revealed that both Resident #4 and Resident #9's call lights were out of their reach. Both call lights were on the floor under the wall mounted call light receptacle (where the call light cord plugs into the wall). On 5/28/26 at 4:15 PM, observation revealed Resident #6 was resting on her bed, and her call light was not within her reach. Both call lights were coiled up on the floor under the wall mounted call light receptacle. Her roommate was not in the room. On 5/28/26 at 4:20 PM, observation and interview revealed the Director of Nursing (DON) confirmed that the call light for Resident #7 was not within the resident's reach. The DON placed the call light in her reach. On 5/28/26 at 4:30 PM, interview with LPN #1 revealed he stated that he was aware that it was the responsibility of the nursing staff to ensure each resident had their call light within their reach. He confirmed that he was assigned to the care for all residents in the locked dementia unit on 5/28/26 from 7:00 AM through 7:00 PM and they did not have their call lights within their reach. He stated, "I know about keeping call lights in reach, it's a safety risk if they need to get help". He confirmed that he had to struggle to retrieve the call lights for both residents in Resident #5 and Resident #8's room. On 5/28/26 at 4:39 PM, during an interview the DON revealed that it is the responsibility of all staff to ensure that each resident had their call light within reach to summon assistance as needed. On 5/28/26 at 4:45 PM, interview with Certified Nursing Assistant (CNA) #4 revealed she was assigned to the care of residents on the locked dementia unit and that she was aware that all residents in their rooms should have their call lights within reach. On 5/28/26 at 5:00 PM, interview with the Administrator revealed she expected each resident to have their call light within reach, the department	F0558		

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F0558 SS = E	Continued from page 2 heads and nurses to monitor for correct call light placement and that the call light placement was important for residents as it was their means to summon assistance as needed.	F0558		
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to provide a safe, functional, and sanitary environment for residents as evidenced by failing to maintain sharps containers in a safe manner for two (2) of four (4) observed sharps containers. Findings Included: Record review of the facility policy “Sharps Container Policy”, undated, revealed “The facility will utilize sharp container as follows: For disposal of all sharp items, (not all inclusive) …Lancets…Sealed with tape and dated when disposed of…” The facility policy did not address when or how often the sharps containers should be emptied. On 5/28/26 at 3:40 PM, during an observation and interview the Director of Nursing (DON) revealed the sharps container in the shower room on the locked dementia unit was full to the point of being unable to be opened and there were three uncapped used aqua-blue disposable razors on the top of the container. The DON confirmed that the sharps container should have been properly disposed of and replaced with a new one and that the razors on top of the container could pose a potential safety hazard to residents. She said that it was the responsibility of the Certified Nursing Assistants (CNAs) to report the full sharps container to the nurses and the responsibility of the nurses to monitor the containers and replace them as needed. On 5/28/26 at 4:15 PM, observation revealed the sharps’ container on the medication cart for the locked dementia unit was full to the point of being unable to be opened. The sharps containers in shower room were overfilled to the point of being unusable with three used, unsheathed disposable	F0921		

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F0921 SS = D	Continued from page 3 razors atop the sharp's container in the shower room. On 5/28/26 at 4:30 PM, interview with Licensed Practical Nurse (LPN) #1 revealed that the sharps' container on the medication cart was full to maximum capacity. He reported that there were two residents that required routine blood glucose monitoring on the unit and that the lancets used to obtain blood specimen would need to be disposed of in a sharps' container. He stated that the sharps' container on the medication cart was not an option because it was so full it could no longer be opened. Concerning the lancets used for glucose monitoring he stated, "they would be thrown in the sharps' container, but obviously not this one because you can't open it". On 5/28/26 at 4:45 PM, interview with CNA #4 confirmed that she was assigned to the care of residents on the locked dementia unit and that residents on the unit used the shower room. On 5/28/26 at 5:00 PM, interview with the Administrator revealed she expected staff to provide for the safety of residents in the shower room and anywhere sharps' containers were located, dispose of them as needed and confirmed that leaving uncapped/unsheathed disposable razors on top of the sharps' container in the locked dementia unit shower room could pose a safety hazard for residents.	F0921		