Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and M995 was cited.	M0000		
M0995	45.34.2 Medical Waste Medical Waste. 1. Medical waste must be kept in water-tight suitable containers with tight fitting covers. Medical waste containers must be emptied at frequent intervals and cleaned before using again. 2. Proper disposition of medical waste materials shall be observed. This LICENSURE 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	M0995		

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

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M0995	Continued from page 1 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 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.	M0995		