STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 02/05/2024 through 02/08/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F584, F641, and F880. The facility had a census of 76 and was licensed for 103 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		3/28/24

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

Electronically Signed | 02/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a comfortable room temperature levels of 71 degrees to 81 degrees Fahrenheit (F) for two (2) of 18 sampled residents. Resident #13 and Resident #9 Findings include: A review of the facility's "Safe and Homelike Environment Policy" dated Apr (April) 23 revealed " Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment ... Policy Guidelines: 7. The facility will maintain comfortable and safe temperature levels ..." Resident #13 On 02/05/24 at 12:53 PM, during an observation and interview with Resident #13, the resident complained the room temperature was too cold for him. He stated had had complained to all the	F 584	1. Thermostat that controls the temperature for residents' #13 and #9 was set to 75 degrees Fahrenheit (°F) auto and locked on 02/08/24. The owner had the thermostat relocated to the hallway on 02/19/24. Between 2/8/24 and 2/19/24, Administrator monitored rooms 17, 19 and 21 daily to ensure temperatures registered between 71-81 °F. 2. All residents have the potential to be affected. 3. On 2/8/24, the Director of Nursing (DON) and Administrator educated Maintenance and Nursing Supervisors on comfortable and safe environmental temperature levels, which should fall between 71-81 °F. 4. Beginning 2/20/24, resident rooms that contain thermostats, the dining room	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 584	Continued From page 2 staff about the room temperature, but nothing had been done. There was no unit or thermostat in the room for the resident to be able to adjust the temperature. On 02/08/24 at 9:52 AM, during a phone interview with Resident #13's wife, she explained the resident had complained about the room temperature being cold. She stated that she made staff aware, including the Administrator and the owner, and was told the system was being worked on. A record review of the "Admission Record" revealed the facility admitted Resident #13 on 05/28/21 with current diagnoses including Heart Failure. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/23, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired. Resident #9 On 02/06/24 at 9:35 AM, during Resident Council Meeting, Resident #9 reported her room stays cold all the time, and that her hallway was also cold. A record review of the "Admission Record" revealed the facility admitted Resident #9 on 02/14/17 with the current diagnoses including Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side.	F 584	and the activities room will be monitored daily by Maintenance and/or Nursing Supervisors for a period of fourteen (14) days. Beginning 3/5/24, rooms and communal areas in the facility will be checked weekly for comfortable and safe environmental temperatures for a period of four (4) weeks. Should any temperature fail to meet the regulatory requirement, the administrator is to be notified immediately. Subsequently, the administrator will take corrective action to obtain comfortable and safe temperature. The temperature check log will be reviewed by the Administrator weekly times six (6) weeks. The Administrator will then report the finding to the Quality Assurance and Assessment (QAA) meeting on 03/27/2024. The QAA committee will review the findings and make recommendations as needed for three (3) months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 584	Continued From page 3	F 584		

Record review of the Annual MDS with an ARD of 11/09/23 revealed Resident #9 had a BIMS score of 13, which indicated she was cognitively intact.

At 4:35 PM on 02/07/24, during an interview with the Administrator, she explained some residents had requested the facility to turn up the thermostat in the building and in their rooms. She reported the heating units are in the attic and the thermostat controls are located throughout the facility. She confirmed that there were some thermostats located in resident rooms and all thermostats were set on 72 degrees or higher.

On 02/08/24 at 10:20 AM, during an observation and interview with Maintenance #1, he explained that Resident #9 and Resident #13's room temperature were controlled by a thermostat located in another resident's room (Room 19). Upon entering Room #19, the thermostat was set on 68 degrees F and was on "cool". The resident in Room #19 stated that she had gotten hot during the night and had to turn on the air conditioner. She confirmed she adjusted the thermostat as she needed. Maintenance #1 confirmed residents have complained about being cold and that the thermostat in Room #19 was not locked to prevent the resident from adjusting the temperature that affected other resident rooms.

At 10:30 AM on 02/08/24, an observation of Resident #13's room (Room #21) with Maintenance #1, revealed the room temperature was 68 degrees when measured using a thermometer. Resident #9's room (Room #17) was 66 degrees initially, but when the thermometer was held near the vent in the ceiling, the thermometer reading increased to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 584	Continued From page 4 69.4 degrees F. On 02/08/24 1:40 PM, during an interview with Administrator, she confirmed the thermostat in Room #19 controls the temperatures for Rooms #16 through #21. She stated that she locked the thermostat in Room #19 and turned the unit to auto, so it would turn off and on. She explained the owner had been working on the thermostats since June 2023 to remove thermostats from resident rooms. She explained that she expected all resident rooms to have a comfortable temperature from 71 degrees F and higher.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and the facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) related to restraints for two (2) of 18 sampled residents. Resident #30 and Resident #36 Findings Include: A review of the facility's "MDS 3.0 Completion Policy", dated October 2023, revealed, " Policy Statement: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan...Policy Guidelines ...4. Care Plan Team Responsibility for Completion go MDS Sections ...a. ii. Persons completing...the assessment must attest to the accuracy of the	F 641	1. Resident #30's Quarterly Minimum Data Set (MDS) 3.0, with an ARD date of 11/30/23, was corrected to accurately code Section P-Restraints, and a corrected MDS was transmitted on 2/09/24. Resident #36's Annual MDS 3.0, with an ARD date of 11/30/23, was corrected to accurately code Section P-Restraints, and a corrected MDS was transmitted on 2/09/24. 2. Residents who may be coded under Section P-Restraints of the MDS have the potential to be affected. 3. LPN #2/ MDS Nurse was educated on 2/09/24 by the Director of Nursing (DON) on accurate coding of the MDS section	3/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 641	Continued From page 5 section they completed ..." Resident #30 During an observation on 2/5/24 at 1:35 PM, Resident #30 was observed to have one full length bedrail on one side of the bed and 1/4 (quarter) length side rail on the other. He stated that he requested the long bedrail to be up at night, and he kept it down during the day to make it easier to get out of the bed. A record review of the "Admission Record" revealed the facility admitted Resident #30 on 10/11/2023 and he had current diagnoses including Chronic obstructive pulmonary disease (COPD) and Type 2 Diabetes Mellitus A record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 11/30/23 revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Review of Section P - Restraints revealed Resident #30 had bed rails coded as "Used Daily". Resident #36 During an observation on 2/5/24 at 1:00 PM, Resident #36 was not in his room, however, there were 1/4 length side rails observed to both sides of the bed. A review of the "Admission Record" revealed the facility admitted Resident #36 on 1/6/2021 and he had current diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side.	F 641	P-Restraints. Residents' MDS's were reviewed for accuracy on 2/08/24 by Licensed Practical Nurse (LPN) #2/MDS Nurse. Corrections to the MDS coding were completed on 2/12/24, and corrected MDS's were transmitted on that date. 4. Beginning on 2/15/24, the DON will monitor the MDS's for accuracy prior to transmission weekly times twelve (12) weeks. The DON will report findings to Quality Assurance and Assessment (QAA) committee beginning on 3/27/24. The QAA committee will review findings and make recommendations as needed for three (3) months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 641	Continued From page 6 A record review of the Comprehensive MDS with an ARD of 11/30/23 revealed Resident #36 had a BIMS score of 6, which indicated severe cognitive impairment. A review of Section P - Restraints revealed Resident #36 had bed rails codes as "Used Daily". During an interview on 02/08/24 at 3:00 PM, with Licensed Practical Nurse (LPN) #2/ MDS nurse revealed that the 1/4 length bedrail on Resident #30 and Resident #36 were coded as a restraint on the MDS because she was trained that if a resident cannot lower the bedrail on their own, then it was to be coded as a restraint. LPN #2 revealed the 1/4 length bedrails are used as an enabler for Resident #30 and Resident #36. On 02/08/2024 at 3:50 PM, an interview with the Director of Nursing (DON) and Administrator revealed she was aware there was an MDS discrepancy regarding restraints and acknowledged the siderails for Resident #30 and Resident #36 were not a restraint but were used as an enabler. She stated that she had a meeting with the MDS nurse and the Administrator regarding bed rails and coding the MDS. The Administrator stated that she expected the MDS to be coded accurately.	F 641		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 880	Continued From page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 880	Continued From page 8 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide peg tube care (Resident #29) and catheter care (Resident #61) in a manner to prevent the possible spread of infection for two (2) of five (5) resident care observations. Findings Include: Review of the facility's "Gastrostomy Site Care Policy", dated 10/23, revealed, " Policy: It is the policy of this facility to perform gastrostomy site care as ordered. Policy Guidelines ...14. Using soap and water/wound cleanser gently clean the area around the tube and continue in an outward circular fashion, ensuring that under the bolster is cleaned ..." Review of the facility's "Hand Hygiene Policy",	F 880	1. On 2/8/24, Director of Nursing (DON) assessed Resident #61 and Resident #29 for signs and symptoms of infection. No signs and symptoms of infection were found. On 2/8/24, Staff Development Coordinator (SDC) in serviced Licensed Practical Nurse (LPN) #1 on appropriate infection control procedures for Percutaneous Endoscopic Gastrostomy (PEG) tube care, and LPN #1 successfully completed return demonstration. On 2/8/24, SDC in-serviced Certified Nursing Assistant (CNA) #1 on infection control procedures while rendering catheter care, and CNA #1 successfully completed return demonstration. 2. All residents who have a foley catheter and/or a PEG tube have the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 880	Continued From page 9 dated 8/23, revealed, "Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. All staff will perform proper hand hygiene procedures to prevent the spread of infection to ...residents ...Policy Guidelines ...6. Additional considerations: 1. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves ..." Resident #29 On 02/07/24 at 3:02 PM, during an observation of Percutaneous Endoscopic Gastrostomy (peg) tube care by Licensed Practical Nurse (LPN) #1 for Resident #29, she cleaned the peg tube insertion site using one (1) gauze, circling the site three (3) times. She did not rotate the gauze or use a new gauze with each circle around the peg tube insertion site. On 02/07/24 at 3:14 PM, in an interview with LPN #1, she confirmed she should have rotated the gauze or changed the gauze with each circle and her actions could have caused the resident to acquire an infection. Record review of the "Admission Record" revealed the facility admitted Resident #29 on 12/09/23 with current diagnoses including Aphasia following Cerebral Infarction. Record review of the "Order Summary Report" revealed Resident #29 had a Physician's Order, dated 12/11/23, to " ...Complete tube site care q (every) day and PRN (as needed)." Record review of the Comprehensive Minimum	F 880	potential to be affected. 3. On 2/27/24, Infection Preventionist (IP) and SDC began in-servicing CNAs on infection control procedures regarding catheter care and licensed nurses on PEG tube care. The aforementioned in-services will be completed by 3/5/24. The in-service training will include return demonstration. 4. Beginning 3/6/24, IP and/or SDC will observe both three (3) Foley Catheter and three (3) PEG tube care procedures per week for a period for 6 weeks. IP will report results to the Quality Assurance and Assessment (QAA) committee on 3/27/24. The QAA committee will review the findings and make recommendations as needed for three (3) months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 880	Continued From page 10	F 880		

Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/23 revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was severely cognitive impaired.

Resident #61

On 2/08/24 at 8:33 AM, an observation of catheter care for Resident #61 completed by Certified Nursing Aide (CNA) #1 revealed CNA #1 washed her hands and applied clean gloves. She filled the wash basin with water and turned the water off while wearing the same gloves. CNA #1 touched the water faucet handle, doorknobs, and the resident's bed linen while wearing the same gloves and did not discard and apply a new clean pair of gloves before providing catheter care.

On 02/08/24 at 8:55 AM, in an interview with CNA #1, she stated she should have changed her gloves and applied a new pair of clean gloves before beginning catheter care because the resident could acquire an infection.

Record review of the "Admission Record" revealed the facility admitted Resident #61 on 3/20/23 with current diagnoses including Retention of Urine and Benign Prostatic Hyperplasia.

Record review of the "Order Summary Report", revealed Resident #61 had a Physician's Order, dated 3/20/23, for "Foley cath (catheter) care every shift."

Review of the Quarterly MDS with an ARD of 12/5/24 revealed Resident #61 had a BIMS score of 5 which indicated he was severely cognitively

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR NURSING CENTER	4347 WEST GAY ROAD DIBERVILLE, MS 39540

(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
F 880	Continued From page 11 Impaired. On 02/08/24 at 10:56 AM, in an interview with the DON, she confirmed CNA #1 should have prepared the wash basin and gathered supplies first and washed her hands and applied clean gloves before initiating catheter care for Resident #61. She stated there was a potential to introduce bacteria to the resident by not conducting catheter care with clean gloves. The DON stated LPN #1 should have gone around the peg tube site once per gauze or swab for Resident #29. She should have discarded it and got a new one to clean the site.	F 880		