

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 000                                                                | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #29250), at the facility, from 6/10/25 through 6/12/25. The SA investigated MS #29250, a facility related incident, related to falls and there was no citation related to the CI. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F583, F867 and F880.                                                                                                                                                                                                                                                                                                                                                                                                                                                              | F 000                                                                      |                                                                                                                          |                            |                                                        |
| F 550<br>SS=D                                                        | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all | F 550                                                                      |                                                                                                                          | 7/9/25                     |                                                        |

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

TITLE

(X6) DATE

Electronically Signed

06/27/2025

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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 550                                                                | <p>Continued From page 1<br/>residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.<br/>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, record review, and facility policy review, the facility failed to maintain privacy during the provision of perineal care for one (1) of four (4) residents observed for care, Resident #22.</p> <p>Findings included:</p> <p>A review of the facility's policy titled "Resident Rights," dated 2/2023, revealed, "The resident has the right to a dignified existence ...7. Privacy and confidentiality. The resident has a right to personal privacy ..."</p> <p>On 6/12/25 at 10:34 AM, during an observation of perineal care provided by Certified Nurse Aide (CNA) #2, the CNA left the resident exposed while she exited the room to get assistance. Resident #22 remained exposed and was pulling</p> | F 550                                                                      |                                                                                                                          |  |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |  |                                                        |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                             |
| F 550                                                                | <p>Continued From page 2</p> <p>at her shirt in an attempt to cover her private area. CNA #2 returned with CNA #1, then later left the room again to retrieve additional towels, once again leaving Resident #22 exposed. The resident continued to pull her shirt down while waiting.</p> <p>On 6/12/25 at 10:59 AM, during an interview with lead CNA #1, she confirmed Resident #22 was left exposed and stated it was a dignity issue. She noted that the resident appeared embarrassed by being exposed.</p> <p>On 6/12/25 at 11:21 AM, during an interview with CNA #2, she confirmed she left the resident exposed twice when she exited the room. She acknowledged that she should have covered the resident and stated it was a dignity issue.</p> <p>On 6/12/25 at 12:57 PM, during an interview with the Director of Nursing (DON), she stated CNA #2 should have covered Resident #22 as much as possible during perineal care and when leaving the room to retrieve supplies. She confirmed it was a dignity issue to leave a resident exposed.</p> <p>A record review of Resident #22's "Admission Record" revealed the facility admitted her on 6/25/19 with diagnoses including Unspecified Dementia.</p> <p>A record review of Resident #22's Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 5/6/25 revealed her cognition was severely impaired.</p> | F 550                                                                      |                                                                                                                          |  |                                                        |
| F 583<br>SS=D                                                        | <p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | F 583                                                                      |                                                                                                                          |  | 7/9/25                                                 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 583                                                                | <p>Continued From page 3</p> <p>§483.10(h) Privacy and Confidentiality.<br/>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br/>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.<br/>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review, and facility policy review the facility failed to ensure the protection of privacy and</p> | F 583                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 583                                                                | <p>Continued From page 4</p> <p>confidentiality of resident care information when clinical instructions were posted in public view without safeguards for one (1) of eighteen (18) sampled residents, Resident #78.</p> <p>Findings included:</p> <p>A review of the facility's policy "Resident Rights", dated 02/2023, revealed, " ...7. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her ... medical records ...a. Personal privacy includes ...medical treatment ...b. The resident has a right to secure and confidential personal and medical records ..."</p> <p>On 6/10/25 at 12:32 PM, during an observation, a sign indicating "NPO" (Nothing by Mouth) was observed posted on the outside of Resident #78's door, in plain view from the hallway.</p> <p>On 6/12/25 at 8:45 AM, during an interview with the Director of Nursing (DON), she stated the signage was posted so staff would know the resident was not to be given anything by mouth. She also stated she was unsure if the resident's family was aware that the sign had been placed on the door.</p> <p>On 6/12/25 at 8:49 AM, during an interview with Resident #78, she stated she had not been asked for permission for the sign to be posted and did not recall being asked about placing the sign on the door.</p> <p>On 6/12/25 at 9:09 AM, during an interview with Certified Nurse Aide (CNA) #1, she stated that CNAs could access residents' care information, including NPO status, via the Kardex and through</p> | F 583                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 583                                                                | <p>Continued From page 5</p> <p>documentation in the electronic health records system.</p> <p>On 6/12/25 at 10:45 AM, during a follow-up interview with the DON, she acknowledged that staff members from departments such as Physical Therapy and Dietary sometimes answer call lights. She stated all staff have access to residents' chart information. She also acknowledged that visitors and family members walking through the hallway could see the NPO sign posted on Resident #78's door, which contained care information that should have remained confidential.</p> <p>On 6/12/25 at 11:32 AM, during a phone interview with Resident #78's Resident Representative (RR), he stated no one asked him for permission to place a sign on the resident's door. He stated the resident had been transferred from another facility with an NPO order, and everyone understood that she should not be fed anything by mouth.</p> <p>A record review of the "Profile" revealed the facility admitted Resident #78 on 4/17/25 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side.</p> <p>A record review of the "Order Details" revealed a physician's order, dated 6/4/25, which indicated Resident #78 received enteral feedings.</p> <p>A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/25 revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately</p> | F 583                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 583                                                                | Continued From page 6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F 583                                                                      |                                                                                                                          |                            |                                                        |
| F 867<br>SS=D                                                        | <p>impaired.</p> <p>QAPI/QAA Improvement Activities</p> <p>CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii)</p> <p>§483.75(c) Program feedback, data systems and monitoring.</p> <p>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:</p> <p>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.</p> <p>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.</p> <p>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.</p> <p>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate,</p> | F 867                                                                      |                                                                                                                          | 7/9/25                     |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 867                                                                | <p>Continued From page 7</p> <p>analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.</p> <p>§483.75(d) Program systematic analysis and systemic action.</p> <p>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.</p> <p>§483.75(d)(2) The facility will develop and implement policies addressing:</p> <p>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;</p> <p>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and</p> <p>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</p> <p>§483.75(e) Program activities.</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) Performance improvement</p> | F 867                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 867                                                                | <p>Continued From page 8</p> <p>activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review, staff interview, and</p> | F 867                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 867                                                                | <p>Continued From page 9</p> <p>facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency, specifically, the facility was cited for failing to provide Percutaneous Endoscopic Gastrostomy (PEG) care in a manner to prevent the possible spread of infection during an annual recertification survey on 2/8/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of four deficiencies cited. F880.</p> <p>Findings include:</p> <p>Record review of the facility's "QAPI Change Process Policy" (undated) revealed, " ...The facility has established and utilized a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained or modified as needed ..."</p> <p>Record review of the "Provider History Profile" revealed the facility received a citation for F880-Infection Control.</p> <p>Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 2/8/2024, revealed the facility received a citation for F880, " ...Based on observation, staff interview, record review, and facility policy review, the facility failed to provide peg tube care and catheter care in a manner to prevent the possible spread of infection ..."</p> | F 867                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  |                                                                                             |                                                                                                                          |                                                        |                            |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                        |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b> |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| F 867                                                                | Continued From page 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |  | F 867                                                                                       |                                                                                                                          |                                                        |                            |
| F 880<br>SS=E                                                        | <p>During the current recertification survey, the facility failed to ensure perineal care was provided in a manner to prevent the possible spread of infection.</p> <p>On June 12, 2025, at 4:15 PM in an interview, the Administrator stated that corrective actions taken after the survey on 2/8/24 included in-service training for staff on the care and cleaning of catheter sites and PEG tube feeding sites.</p> <p>Infection Prevention &amp; Control<br/>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control<br/>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.</p> <p>§483.80(a) Infection prevention and control program.<br/>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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 §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and</p> |                                                                            |  | F 880                                                                                       |                                                                                                                          |                                                        | 7/9/25                     |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 880                                                                | <p>Continued From page 11</p> <p>procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                        |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b>                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 880                                                                | <p>Continued From page 12</p> <p>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure perineal care was provided in a manner to prevent the possible spread of infection when a Certified Nurse Aide (CNA) failed to perform hand hygiene during care for one (1) of four (4) residents observed for care, Resident #22.</p> <p>Findings included:</p> <p>A review of the facility's "Hand Hygiene Policy," dated 8/23, revealed, " ...The 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 ...Policy Guidelines ...6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves ..."</p> <p>On 6/12/25 at 10:34 AM, during an observation of perineal care provided by Certified Nurse Aide (CNA) #2, she began to assist Resident #22 and then stated, "I need some help." She removed her gloves and exited the room without performing hand hygiene. She returned, did not perform hand hygiene but applied gloves and continued care. After completing care, she removed her gloves and applied a new pair before applying a clean brief, but did not perform hand hygiene before donning (putting on) the gloves.</p> <p>On 6/12/25 at 10:59 AM, during an interview with lead CNA #1, she confirmed CNA #2 did not</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  |                                                                                             |                                                                                                                          |                                                        |                            |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255323</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                        |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/12/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENBRIAR NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4347 WEST GAY ROAD<br/>DIBERVILLE, MS 39540</b> |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| F 880                                                                | <p>Continued From page 13</p> <p>perform hand hygiene several times after removing gloves and that hand hygiene should be performed each time staff enter or exit a room and between glove changes during perineal care.</p> <p>On 6/12/25 at 11:21 AM, during an interview with CNA #2, she admitted she did not perform hand hygiene each time she removed gloves or reentered the room.</p> <p>On 6/12/25 at 12:57 PM, during an interview with the Director of Nursing (DON), she stated CNA #2 should have performed hand hygiene when entering and exiting the room and between glove changes.</p> <p>On 6/12/25 at 3:29 PM, during an interview with Registered Nurse (RN) #1, the facility's Infection Preventionist, she stated CNA #2 should have washed her hands and donned clean gloves each time she entered or exited the room. She confirmed that Resident #22 could develop an infection from lapses in hand hygiene.</p> <p>A record review of Resident #22's "Admission Record" revealed the facility admitted her on 6/25/19 with diagnoses including Unspecified Dementia.</p> <p>A record review of Resident #22's Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 5/6/25 revealed her cognition was severely impaired.</p> |                                                                            |  | F 880                                                                                       |                                                                                                                          |                                                        |                            |