MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24GN	A. BUILDING: _____ B. WING _____	06/12/2025

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

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M 000	Initial Comments 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 #29252, a facility related incident, related to falls and there was no citation related to the CI. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 and M1570.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		7/9/25

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M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

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M 500	Continued From page 2	M 500		

facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain privacy during the provision of perineal care (Resident #22) and failed to ensure the protection of resident #78 privacy by staff posting clinical information, including NPO (Nothing by	M 500		

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M 500	Continued From page 4	M 500		

mouth), on the outside of residents' doors in public view without safeguards to maintain confidentiality (Resident #78) for two (2) of 18 sampled residents.

Findings included:

A review of the facility's policy titled "Resident Rights," dated 2/2023, revealed, "The resident has the right to a dignified existence ...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 ..."

Resident #22

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 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.

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.

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

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M 500	Continued From page 5	M 500		

acknowledged that she should have covered the resident and stated it was a dignity issue.

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.

A record review of Resident #22's "Admission Record" revealed the facility admitted her on 6/25/19 with diagnoses including Unspecified Dementia.

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.

Resident #78

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.

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.

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

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M 500	Continued From page 6	M 500		

not recall being asked about placing the sign on the door.

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 documentation in the electronic health records system.

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.

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.

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.

A record review of the "Order Details" revealed a physician's order, dated 6/4/25, that indicated Resident #78 received enteral feedings.

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M 500	Continued From page 7 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 impaired.	M 500		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Based on observation, interview, record review,	M1570		7/9/25

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M1570	Continued From page 8	M1570		

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.

Findings included:

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 ..."

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.

On 6/12/25 at 10:59 AM, during an interview with lead CNA #1, she confirmed CNA #2 did not 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.
On 6/12/25 at 11:21 AM, during an interview with

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M1570	Continued From page 9 CNA #2, she admitted she did not perform hand hygiene each time she removed gloves or reentered the room. 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. 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. A record review of Resident #22's "Admission Record" revealed the facility admitted her on 6/25/19 with diagnoses including Unspecified Dementia. 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.	M1570		