

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/19/2026	
NAME OF PROVIDER OR SUPPLIER GREENBRIAR NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4347 WEST GAY ROAD , DIBERVILLE, Mississippi, 39540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
M0000	Initial Comments		M0000				
	The State Agency (SA) conducted a Complaint Investigation (CI MS #2742738) at the facility from 03/18/26 through 03/19/26. CI MS #2742738 was a facility reported incident regarding a resident fall. During the survey, the SA determined that based on implementation of the facility's corrective actions on 2/12/2026, the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The deficient practice was determined to be Past Non-Compliance (PNC), and the facility was in compliance effective 2/13/2026 and was cited M640.						
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was free from accident hazards during bed mobility when a Certified Nursing Aide (CNA) performed a linen and brief change without the required two (2) person assistance, in which Resident #1 fell from the bed and sustained a proximal humeral fracture (a break in the upper arm bone near the shoulder), for one (1) of three (3) residents reviewed for accidents. Findings include: A record review of the facility's investigation, undated, revealed that on 2/11/2026, at approximately 10:05 PM, CNA #1 was providing in-bed care to Resident #1, including a linen and brief change. During care, Resident #1 rolled to assist. She subsequently rolled too far and exited the bed, landing on the floor.		M0640				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0640	Continued from page 1 A record review of the "Incident Witness Statement", dated 2/11/26 and signed by CNA #1 revealed a "Narrative if incident if witnessed" which indicated the CNA was changing the resident and went to pull the sheet from under her and the resident rolled and fell. The CNA documented, "...the brief was already on her and I also tried to reach over and keep her from falling and she wasn't able to hold herself up even after grabbing the rail..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 7/14/25 with diagnoses including hypertension with an additional diagnosis added on 2/14/26 of other displaced fracture of upper end of left humerus, subsequent encounter for fracture with routine healing. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated she was cognitively intact. A review of Section GG revealed Resident #1 required substantial/maximal assistance for rolling left and right in bed. A record review of the "Kardex Report as of 2/11/26" revealed Resident #1 required two (2) staff to turn and reposition in bed. A record review of the "XR (X-Ray) Shoulder Complete Left (Routine)," dated 2/11/26, revealed, "History: Shoulder injury from fall out of bed," and the impression indicated Resident #1 had a proximal humeral fracture. A record review of the "Disciplinary Conference," dated 2/12/26, revealed CNA #1 received an infraction for failing to follow the resident's plan of care. On 3/18/26 at 8:49 AM, during an observation and interview, Resident #1 explained that during a linen change on 2/11/26, the CNA rolled her onto her side and removed the bed pad, causing her to begin falling from the bed. The resident reported she attempted to stop herself, and the CNA attempted to catch her, but she continued to fall and landed on her left side. The resident reported the CNA left the room to obtain assistance, and nursing staff came to assess her before she was transported to the hospital. An observation of the room revealed the bed was at an average height. On 3/18/26 at 10:51 AM, during an interview with Certified Nursing Aide (CNA) #1, she explained she was performing a linen and brief change alone. She stated		M0640				

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M0640	Continued from page 2 she rolled the resident to provide care and remove soiled linens when the resident fell from the bed. She explained CNAs have access to a Kardex system that identifies care needs and that staff are expected to review it daily. She reported she was unsure how many staff were required for bed mobility at that time. She confirmed she participated in a disciplinary conference and in-service following the incident. On 3/19/26 at 9:45 AM, during an interview with the Director of Nursing (DON), she explained the resident fell from the bed during a linen change when the CNA did not follow the care plan requiring two (2) staff for bed mobility. She stated staff are expected to review the Kardex daily for updated care needs. She explained that following the incident, monitoring was implemented to ensure staff review the Kardex and follow the care plan, with results reviewed in Quality Assurance and Performance Improvement (QAPI) and interdisciplinary meetings. Review of the facility's "Corrective Action Plan," dated 2/12/26, revealed the President, Director of Nursing (DON), and Administrator spoke to the injured resident's family members. The President, DON, and Administrator interviewed Certified Nursing Aide (CNA) #1, Licensed Practical Nurse (LPN) #1, LPN #2, and LPN #3. A one-to-one (1:1) in-service and disciplinary conference was conducted with LPN #2 related to calling the DON for any falls or hospital transfers, and an in-service and disciplinary conference was completed by the DON. A one-to-one (1:1) in-service was conducted with LPN #1 related to calling the DON for any falls or hospital transfers and completing incident reports, and the in-service was completed by the DON. A one-to-one (1:1) in-service and disciplinary conference was conducted with CNA #1 related to following the plan of care, bed mobility, making an occupied bed, and incontinence care, with return demonstration completed with the DON. The plan further revealed no nursing staff were allowed to work until they were in-serviced on following the care plan, and in-services were completed by the Administrator, Chief Nursing Officer, and DON. A Quality Assurance and Performance Improvement (QAPI) meeting was held via telephone with the medical director and QAPI team members, during which policy was reviewed and no changes were made. The plan revealed the Lead CNA or DON would monitor care at least three (3) times weekly for compliance with care plans related to activities of daily living (ADL) care, the interdisciplinary team would meet weekly to discuss outcomes of observations for six (6) weeks, and observations would be reported to QAPI for two (2) months.			M0640			

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M0640	Continued from page 3 Based on implementation of the facility's corrective actions on 2/12/2026, the deficient practice was determined to be Past Non-Compliance (PNC) and the facility was in compliance effective 2/13/2026 Validation: The SA validated on 3/19/2026, through interview and record review, that all corrective actions had been implemented as of 2/12/2026, and the facility was in compliance on 2/13/2026, prior to the SA's entrance on 3/18/2026.			M0640			