

PRINTED: 04/16/2019
FORM APPROVED

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255323	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2019
NAME OF PROVIDER OR SUPPLIER GREENBRIAR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 WEST GAY ROAD DIBERVILLE, MS 39540		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
M000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted on 3/28/19, the facility was in compliance for State Licensure requirements. No deficiencies were cited.	M000			

Mississippi State Department of Health

TITLE

(X6) DATE

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

Electronically Signed

04/10/2019

*Sheila M. Bachtel**Administrator 4/12/19*