STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195301	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Community Care Center	505 Robert Blvd. Slidell, LA 70458

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 Based on record reviews and interviews, the facility failed to ensure an allegation of sexual abuse was reported to the administrator, state agency and the local law enforcement in the appropriate time frame for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for abuse. Findings: Review of the facility's policy titled, Abuse Components Plan Elder Justice Act and Affordable Care Act with a revision date of 10/24/2022, revealed, in part, the following: Identification: Immediately upon discovery of any alleged and or suspected incident of abuse ., staff is communicating a verbal report to the Charge Nurse and/or Department Head. Reporting: 1. All alleged violations involving abuse .will be reported by the Administrator or designee, to the following persons or agencies as required to provide notification: a. State agency online tracking incident system. d. Law enforcement officials . 2. An alleged violation involving abuse .will be reported immediately, but no later than: a. Two hours if the alleged violation involves abuse . Review of the clinical record for Resident #1 revealed she was admitted to the facility on [DATE]. Review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated Resident #1 was cognitively intact. (continued on next page)

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.

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

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NAME OF PROVIDER OR SUPPLIER Greenbriar Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Robert Blvd. Slidell, LA 70458	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Notes for Resident #1 dated 02/11/2025 at 1:44 a.m., revealed S3LPN documented Resident #1 called her into her room stating, Some man is in here, feeling me down. Review of the Incident/Accident Log dated December 2025 through present revealed no entry for Resident #1 for 02/11/2025. On 03/12/2025 at 8:40 a.m., an interview was conducted with S3LPN. She confirmed she worked 02/11/2025 from 11:00 p.m. to 7:00 p.m. S3LPN stated Resident #1 reported a man was in her room, lifted her shirt up and was feeling her breast. S3LPN stated Resident #1 reported the man was in her room for 15 minutes. S3LPN stated she did not feel like this was an emergency and did not report this allegation immediately to her supervisor. She stated she reported this allegation of sexual abuse to S4LPN on 02/11/2025 at 6:00 a.m. by telephone. On 03/12/2025 at 9:30 a.m., an interview was conducted with S4LPN. S4LPN stated she was never notified of a sexual abuse allegation made by Resident #1 on 02/11/2025. She stated she would expect staff to report all sexual abuse allegations immediately to their supervisor. On 03/13/2025 at 1:45 p.m., an interview was conducted with S2DON. He stated he expected staff to report all allegations of sexual abuse immediately. He stated when Resident #1 alleged she was sexually abused to a staff member, the staff member should have reported the alleged abuse immediately to a supervisor. He confirmed he was not aware of an allegation of sexual abuse made by Resident #1 on 02/11/2025. On 03/13/2025 at 1:50 p.m., an interview was conducted with S1ADM. She stated she expected staff to report all allegations of sexual abuse immediately. She stated when Resident #1 alleged she was sexually abused to a staff member, the staff member should have reported the alleged abuse immediately to a supervisor. She confirmed she was not aware an allegation of sexual abuse was made by Resident #1 on 02/11/2025 and she did not notify the law enforcement or the state agency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 52121 Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status for 1 (#2) of 3 (#1, #2, and #3) residents reviewed for MDS. Findings: Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included, in part, mild intellectual disabilities. Review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed the following, in part: Behavioral Symptoms - Presence & Frequency: Physical behavioral symptoms directed toward others was coded as 0, which indicated the behavior was not exhibited. Review of Resident #2's Nursing Notes dated 11/25/2024 revealed the following, in part: Resident #2 was in the dining room and pulled off the head band of another resident's head and stated that it was hers. Signed by S5LPN. On 03/13/2025 at 1:32 p.m., an interview was conducted with S6SSD. S6SSD stated she was responsible for completing resident's MDS Behavior assessments. S6SSD reviewed Resident #2's nursing progress note dated 11/25/2024 indicating she pulled the head band off of another resident and stated that it was hers. S6SSD confirmed she would consider this a physical behavior. S6SSD reviewed Resident #2's Quarterly MDS with an ARD of 11/27/2024 and confirmed Resident #2 was not coded for physical behaviors and should have been. On 03/13/2025 at 1:45 P.M., an interview was conducted with S2DON. S2DON reviewed the above mentioned findings and confirmed Resident #2's MDS was not coded for physical behaviors and should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 52121 Based on interviews and record reviews the facility failed to ensure a resident's comprehensive plan of care was developed and implemented for 1 (#2) of 3 (#1, #2 and #3) residents reviewed for care plans. The facility failed to ensure Resident #2's care plan was developed for wandering behaviors. This deficient practice had the potential to affect the current 28 residents residing on E Hall. Findings: Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included, in part, mild intellectual disabilities. Review of Resident #2's most recent Care Plan did not address or provide interventions for Resident #2's wandering behaviors. An interview was conducted with S7CNA on 03/11/2025 at 12:54 p.m. S7CNA stated Resident #2 is known to wander into other resident rooms. S7CNA stated that redirection techniques, including art and coloring, are used as interventions when Resident #2 exhibits disruptive behaviors such as wandering or shouting. S7CNA stated the resident's care plan does not specify a need for increased supervision. An interview was conducted with Resident #3 on 03/11/2025 at 1:25 p.m. Resident #3 stated Resident #2 wandered into his room uninvited. Resident #3 did not recall any prior incidents like this. Resident #3 recalled that when staff saw Resident #2 in his room, staff immediately removed her. An interview was conducted with S5LPN on 03/13/2025 at 12:35 p.m. S5LPN stated that she is responsible for E Hall care plans. S5LPN stated she is aware Resident #2 is known to wander into other resident rooms' uninvited. S5LPN stated staff will redirect Resident #2's attention when that behavior occurred. S5LPN confirmed Resident #2 should be care planed for these behaviors and was not. An interview was conducted with S2DON on 03/13/2025 at 1:45 p.m. He reviewed Resident #2's care plan and confirmed Resident #2 was not care planned for wandering behaviors and should have been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47173 52121 Based on record reviews, observation, and interviews the facility failed to revise and implement a comprehensive person-centered care plan which met the needs of 1 (#2) of 3 (#1, #2 and #3) sampled residents. Findings: Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses which included, in part, mild intellectual disabilities. Review of Resident #2's most recent Care Plan dated 03/10/2024 revealed the following: Problem: I have a behavior problem. I am sexually inappropriate at times and I act out when I don't get my way. Review of Resident #2's nursing progress notes, dated 11/10/2024, revealed Pt pulled up shirt showing breasts in dining area. Signed per S9LPN. An interview was conducted with S7CNA on 03/11/2025 at 12.54 P.M. S7CNA stated she had been employed at this facility for approximately six months and cares for Resident #2. S7CNA did not recall the incident noted 11/10/2024 but knew Resident #2's care plan included inappropriate sexual behaviors. S7CNA stated that redirection to a different activity, like coloring, was her intervention when Resident #2 displayed disruptive or sexually inappropriate behaviors. An interview was conducted with S5LPN on 03/13/2025 at 11:30 a.m. S5LPN confirmed she was responsible for E Hall residents' care plans. S5LPN stated she was aware of the incident on 11/10/2024 and would consider it sexual. S5LPN confirmed the care plan should have been revised after the incident and was not. An interview was conducted with S1ADM on 03/13/2025 at 12:50 P.M. S1ADM stated she reviewed video footage on 11/10/2024 and it revealed Resident #2 lifting her shirt in the common area in front of other residents. S1ADM stated this was considered a behavior. An interview was conducted with S9LPN on 03/13/2025 at 1:04 P.M. S9LPN stated she was caring for and remembered the incident on 11/10/2024. S9LPN stated Resident #2 lifted her shirt up in the common area in front of other residents. S9LPN stated Resident #2 was removed from the area and reported this to S5LPN. An interview was conducted with S2DON on 03/13/2025 at 1:45 P.M. S2DON reviewed the aforementioned incident and confirmed Resident #2's care plan should have been revised after the incident on 11/10/2024 and was not.