STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255323	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Nursing Center	4347 West Gay Road Diberville, MS 39540

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. 41306 Based on staff interview, record review, and facility policy review, the facility failed to report an allegation of sexual abuse within two (2) hours, as required, when Resident #1 verbalized she was sexually abused for one (1) of three (3) sampled residents. Findings included: A review of the facility's, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy, revised in August 2023, revealed, It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment .immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations with prescribed timeframes . Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation . Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline . A record review of the Admission Record revealed the facility admitted Resident #1 on 09/13/2024 with diagnoses including Dementia and Alzheimer's Disease. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/23/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated her cognition was severely impaired. A record review of the facility's investigation of the alleged sexual abuse revealed that on 11/01/2024 at approximately 11:50 PM, Resident #1 exited her room with a bowel movement on her body and stated, There is so much blood, she raped me, there is so much blood. A record review of the local hospital Admission Note dated 11/02/2024 at 9:07 AM revealed, .she was yelling she was raped. (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

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 11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Nursing Center	4347 West Gay Road Diberville, MS 39540

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	On 11/12/2024 at 10:25 AM, during an interview, the Administrator stated that on 11/02/2024 at 1:18 AM, Resident #1 complained of rectal bleeding and was sent to the local emergency department. On 11/06/2024, the Administrator received a call from the case manager at the hospital reporting that a complaint would be submitted to the State Agency (SA) and the Attorney General regarding an allegation of rape at the facility. Upon receiving this information, the Administrator initiated an investigation and discovered that on 11/02/2024 at approximately 1:18 AM, Resident #1 walked out of her room with feces and blood and stated she must have been raped. The investigation revealed that Licensed Practical Nurse (LPN) #1 and Certified Nurse Assistants (CNAs) #1 and #2 were aware of the allegation on 11/02/2024 but did not report it to the Administrator or Director of Nursing (DON). The facility began their investigation on 11/06/2024 and was unable to substantiate that abuse occurred. The Administrator confirmed the facility's policy requires reporting allegations of rape to the SA, local police, and Attorney General within two (2) hours of the allegation. The facility's administration did not report the allegation on 11/02/2024 because they were unaware of the situation until 11/06/2024. On 11/12/2024 at 1:21 PM, during an interview, the DON confirmed that during the facility's investigation, there were three (3) staff members who stated that Resident #1, following a bowel movement with bleeding on 11/2/24, felt as if she was raped. The DON stated the facility was not aware of the allegation on 11/02/2024 because none of the staff informed the administration. The DON emphasized that staff should have notified her or the Administrator immediately to ensure reporting to the SA, local police, and Attorney General within two (2) hours. On 11/12/2024 at 2:20 PM, during an interview, LPN #1 confirmed that on 11/02/2024 at approximately 1:30 AM, Resident #1 appeared confused, walked out of her room with bowel and blood observed, and stated, with all this blood, I must have been raped. LPN #1 confirmed the Nurse Practitioner was notified about the bleeding, but admitted the Administrator or DON was not notified that Resident #1 said she had been raped because LPN #1 believed there was no basis for the allegation. A record review of CNA #1's witness statement revealed, .resident did not want anyone to touch her and stated rape. A record review of CNA #2's witness statement revealed, .she was saying it was so much blood and something about rape.