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	03/19/2026

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to implement the comprehensive person-centered care plan requiring two (2) staff to assist with bed mobility, when staff provided care without the required assistance, resulting in the resident falling from the bed and sustaining a proximal humeral fracture (a break in the upper arm bone near the shoulder) for one (1) of three (3) sampled residents (Resident #1) .Findings include:A record review of the Care Plan Report revealed Resident #1 had a focus of an ADL (activities of daily living) self-care performance deficit with interventions initiated on 7/14/25 that included, BED MOBILITY: The resident requires x (times) 2 staff to turn and reposition in bed.A record review of the facility's investigation revealed that on 2/11/26 at 10:05 PM, Certified Nursing Aide (CNA) #1 was providing in-bed care to Resident #1, including a linen and brief change. During care, the resident rolled to assist and subsequently rolled too far, exiting the bed and landing on the floor.A record review of the Incident Witness Statement, dated 2/11/26, 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 when 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 was not 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 the resident 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 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 break in the upper arm bone near the shoulder).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 interview with Resident #1, the resident explained CNA #1 was changing her bed linens alone on 2/11/26 when she fell from the bed.On 3/18/26 at 10:51 AM, during an interview with CNA #1, she confirmed she was the only staff member present while providing care. She explained she rolled the resident to remove soiled linens and replace them with clean linens when the resident fell from the bed.On 3/19/26 at 9:30 AM, during an interview with Registered Nurse (RN) #1, Care Plan Nurse, she explained that upon admission, she collaborates with nursing staff, CNAs, therapy, and dietary to assess resident needs and develop care plans. She stated she observes care to identify resident-specific needs and updates care plans quarterly, annually, and as needed.On 3/19/26 at 9:45 AM, during an interview with the Director of Nursing (DON), she explained Resident #1 had a person-centered care plan requiring (2) staff for bed mobility. She confirmed the CNA did not follow the care plan. She stated staff are expected to review the Kardex daily for updated care needs.Review of the facility's Corrective Action Plan, dated 2/12/26, revealed the President, Director (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	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.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 2/13/2026Validation: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.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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. 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 (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.During an observation and interview on 3/18/26 at 8:49 AM, Resident #1explained 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.During an interview with Certified Nursing Aide (CNA) #1 on 3/18/26 at 10:51 AM, she explained she was performing a linen and brief change alone. She stated 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.During an interview with the Director of Nursing (DON) on 3/19/26 at 9:45 AM, she explained the resident fell from the bed during a linen change when the CNA did not follow the Kardex requiring (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, 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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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.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 2/13/2026Validation: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.