STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365853	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Center	8064 South Avenue Boardman, OH 44512

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** 48567 Based on medical record review, review of the facility's self-reported incident (SRI), interviews and review of the facility policy, the facility failed to ensure timely and appropriate reporting of suspected verbal abuse and rough handling of Resident #75 by staff. This affected one resident (#75) of 33 residents residing on the Regency unit of the facility. The facility census was 100. Findings include: Review of the medical record revealed Resident #75 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, mild intellectual disabilities, asthma, atherosclerotic heart disease of the native coronary artery, essential hypertension, iron deficiency anemia, obstructive reflux uropathy, bipolar disorder, muscle weakness, glaucoma, and unspecified chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed 11/04/24 revealed Resident #75 had severe cognitive impairment and was dependent for toileting hygiene, dressing lower body, application and removal of footwear, and personal hygiene. Further review of the MDS revealed Resident #75 was frequently incontinent of urine and stool and exhibited no behaviors or rejection of care. Review of the care plan dated 11/04/24 revealed Resident #75 was incontinent of urine and was at risk for urinary complications related to malignant neoplasm of the prostate, benign prostatic hyperplasia (BPH), impaired cognition, impaired mobility, and obstructive uropathy. Interventions included the application of barrier creams as needed, wash, rinse, and dry perineum, and change disposable briefs and/or clothing after incontinent episodes. Further review of the care plan revealed Resident #75 had behavior problems related to mild intellectual deficits, bipolar disorder, and impaired cognition, including taking items that did not belong to him, being loud, exhibiting periods of sadness, and agitation when needs not immediately met. Interventions included approaching and speaking with Resident #75 in a calm manner. Review of the progress note dated 11/27/24 at 3:20 P.M. revealed the Executive Director and the Director of Nursing (DON) notified Resident #75's emergency contact that there was an allegation of verbal abuse. Resident #75 could not recall the incident, and no concerns were noted with his skin assessment. Accused staff member was suspended pending further investigation, and the [NAME] police were in the facility to follow-up. There were no progress notes between 11/24/24 and 11/27/24 at 3:20 P.M. indicating report of alleged abuse of Resident #75. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/27/24 at 10:51 A.M. with the DON revealed he had received no report of suspected abuse, neglect, or mistreatment of a resident in the past week (review of the complaint intake information revealed the alleged abuse took place between 10:00 A.M. and 11:00 A.M. on 11/24/24). The DON further confirmed immediate reporting was necessary in order for the facility to take necessary steps to ensure immediate resident safety. Interview on 11/27/24 at 10:53 A.M. with the Executive Director (ED) confirmed he had not received any report of allegations regarding abuse or neglect of a resident by staff. The ED further detailed the facility's reporting and investigative process when such allegations occurred and concurred abuse allegations should be reported immediately. Follow-up interview with the ED and the DON on 11/27/24 from 10:58 A.M. to 11:03 A.M. confirmed there was one certified nurse aide (CNA) who had the first name of the staff member identified as the perpetrator in the complaint (CNA #409). During the interview, the ED immediately called the Scheduling Coordinator #365 to verify CNA #409 was not on duty and verbalized CNA #409 would be suspended pending an investigation, and he would file a facility SRI to the state agency. Interview on 11/27/24 at 1:25 P.M. with CNA #409 confirmed she worked on the Regency unit on 11/24/24. During the interview, CNA #409 denied any verbal abuse, physical abuse, or mistreatment of any type to any resident. She further stated this was not the first time she was accused of something in this facility and was tired of false accusations. Interview on 11/27/24 at 2:35 P.M. with the DON confirmed he had just learned a CNA (#379) just admitted to witnessing an incident between CNA #409 and Resident #75 on 11/24/24. At the time of this interview, CNA #379 was being interviewed by the ED, writing her statement, in the process of being suspended, and then would be speaking with the [NAME] police officer waiting outside the EDs office. Interview on 11/27/24 at 3:00 P.M. with CNA #379 confirmed she was instructed by CNA #409 to assist in cleaning up Resident #75 between 10:00 A.M. and 11:00 A.M. during her shift on 11/24/24. CNA #379 stated she witnessed CNA #409 running a large handful of wipes under water, throwing the wipes with force at Resident #75, telling him to clean your [expletive] self, shoving his shoulder to turn him against the wall, and calling him a disgusting [expletive]. Further interview revealed CNA #379 witnessed CNA #409 pull and wipe Resident #75's scrotum and surrounding area so roughly that Resident #75 groaned, and CNA reported Resident #75 to be clenching with a reddened face and a look of confusion and helplessness. During the interview, CNA #379 admitted she was shocked and scared and did not know what to do to help Resident #75. CNA #379 further confirmed she had received training on abuse reporting expectations, but was too afraid, so she called a friend, who was an aide who worked elsewhere, for advice and that friend called and reported an anonymous complaint to the Ohio Department of Health (ODH). During the interview, CNA #379 confirmed she told nobody who worked in the facility she witnessed verbal abuse and rough care by a co-worker (CNA #409) and that co-worker continued to work with the residents of the facility after the witnessed incident. Interview on 12/02/24 at 12:44 P.M. with Resident #75's family confirmed the facility notified her on 11/27/24 that there was an alleged incident of abuse of Resident #75 on Sunday, 11/24/24. The family of Resident #75 confirmed Resident #75 had no recollection of the incident and was unable to provide any details of that day. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/24 with Resident #75 at 12:50 P.M. confirmed he had no recollection of the incident reported on 11/24/24. Further interview confirmed he felt safe in the facility and could provide no details related to verbal or physical abuse. Review of the in-process investigation for SRI tracking number(#)254531 revealed a witness statement written by CNA #379 on 11/24/24 confirming she witnessed Resident #75 receiving incontinence care from CNA #409 and that CNA #409 was angry, called Resident #75 names, swore at him, shoved his shoulder to the wall to turn him around, and wiped him so hard she was nearly knocking him over. Further review of the witness statement revealed CNA #379 did not intervene and did not report the allegation to anyone in the facility. Further review of the SRI investigation revealed CNA was suspended on 11/27/24 for failure to report allegations of abuse. Review of the undated policy titled Ohio Abuse, Neglect & Misappropriation revealed a covered individual, defined as anyone who is an owner, operator, employee, manager, contractor, or agent of the facility, was obligated to report any reasonable suspicion of a crime against a resident or person receiving care in a long-term care facility. The policy further revealed employees received training on abuse prevention and reporting as part of their orientation, annually, and as needed or indicated. The policy also revealed any suspected abuse or neglect was to be reported directly to the supervisor and reported immediately to the Executive Director or facility designee and investigated timely. This deficiency is an incidental finding identified during the complaint investigation.