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	12/07/2023

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observations, review of the medical record and interview with the staff, the facility failed to ensure blood sugar tests and insulin was administered as ordered for Resident #78, failed to ensure the call light was answered timely for Resident #15 and failed to ensure an intravenous antibiotic was initiated timely after admission for Resident #99. This affected two residents (Resident #78 and #99) of three reviewed for medication administration and one resident (Resident #15) of three reviewed for staffing. The facility census was 97. Findings included: 1. Review of the medical record revealed Resident # 78 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, anemia, acute cystitis, severe protein calorie malnutrition, encephalopathy, diabetes, diabetic neuropathy, cognitive communication, hemiplegia, gastrostomy, and weakness. Review of the Five-Day Medicare Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #78 had moderately impaired cognition, he had a tube feed for nutrition and received insulin. Review of the December 2023 Medication Administration Record (MAR) revealed Resident #78 was ordered to be administered 35 units of Lantus insulin subcutaneously two times daily for diabetes and was to be given at 9:00 A.M. and 9:00 P.M Humalog insulin was to be given per sliding scale after blood sugar testing at 7:00 A.M., 11:00 A.M., 4:00 P.M. and 9:00 P.M Lispro insulin eight units was to be given with meals at 8:00 A.M., 11:30 A.M. and 4:00 P.M. Further review of the December 2023 MAR revealed on 12/05/23 the 9:00 A.M. dose of Lantus was administered at 12:57 A.M., the 8:00 A.M. dose of lispro was not administered, the 11:30 A.M. dose of lispro was administered at 1:27 P.M. and the 11:00 A.M. dose of Humalog insulin per sliding scale of four units was administered at 1:27 P.M. for a blood sugar of 278. Observation on 12/05/23 at 12:32 P.M. revealed Registered Nurse (RN) #102 , RN #103 and Regional RN #104 were at the nurse's station passing medications. Further observation of the electronic medication administration computer screen for RN #102 revealed all the medication's to be administered to Resident #78 so far that day were colored red (red meaning they were not administered and were late). RN #102 verified the medications were late as she was still administering the morning medication to Resident #78. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/23 at 1:15 P.M. an interview with RN #102 revealed she had not administered Resident #78 morning medication until 12:40 P.M. She stated Resident #78 was a peg tube (percutaneous endoscopic gastrostomy tube). She also stated she had not administered his 9:00 A.M. dose of the 35 units of Lantus insulin until almost 1:00 P.M. and she stated she had not administered his 8:00 A.M. or 11:30 A.M. lispro yet but she had just checked his blood sugar, which was 278, and was going to go give him his 11:30 A.M. Lispro now. She stated she would be holding his 8:00 A.M. dose and only administering his 11:30 A.M. dose. She stated they had two nurses call off so the nurse managers were trying to get the medication administered to the residents. Review of the nurse's notes dated 12/05/23 at 5:32 P.M. revealed the Nurse Practitioner was notified of the missed dose of insulin and she had no new orders but to continue to monitor his blood sugars as ordered. 2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included breast cancer, severe protein calorie malnutrition, hypertension, hypothyroidism , osteoarthritis of bilateral knees, COVID-19, lymphedema, anxiety disorder, congestive heart failure, polyneuropathy, respiratory failure, urogenital implants, and acute myocardial infarction. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #15 had intact cognition and was occasionally incontinent of bladder and continent of bowel. Observation on the Providence Unit on 12/05/23 at 10:00 A.M. revealed several call lights were activated including Resident #15's call light. State tested Nursing Assistant (STNA) # 110 was looking for another nursing assistant to help her transfer a resident with the mechanical lift. STNA #111 was behind the nurse's station looking for something in a cupboard, STNA #112 was standing at the nurse's station filling out an incident report and STNA #113 was in a room providing care. Two nurses were passing medications. Continued observation on the Providence Unit from 10:10 A.M. to 10:35 A.M. revealed the call light for Resident #15 was on the whole time. At 10:35 A.M. this surveyor walked down the hall and passed Resident #15's room while on the way to the LifeStyles unit at the end of the Providence unit, did a short observation of the Lifestyles unit and walked back over to the Providence Unit and stopped at Resident #15's room. On 12/05/23 at 10:40 A.M. an interview with Resident #15 revealed she had to use the bedpan and only had female aides provide her care because she had never been married. She stated she turned her call light on at 10:00 A.M. and STNA #111 had come into her room about 10 minutes after she turned it on and said he would get one of the girls to put her on the bedpan. She stated he was going to turn her call light off but she told him to leave it on because no one would come to help her if he turned it off. She stated it took forever to get someone to do anything for you. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/23 at 10:43 A.M. an interview with RN #105 verified Resident #15's call light was on but he was not aware of how long it had been on. At this time, he went into her room and asked her what she needed and she told him she was waiting on an aide to put her on the bedpan. H went down to the nurse's station and STNA #112 was still standing at the nurse's station filling out an incident form. He asked her to go answer the call light in Resident #15's room and she told him she needed to fill out the incident report first so she could turn it into the office . He told her resident care took priority. She stated she would get the call light as soon as she was done. She stated it was not like she would not answer the call light. He told her to come with him and they went down to Resident #15's room to assist the resident. 3. Review of the medical record revealed Resident # 99 was admitted to the facility on [DATE] at 5:00 P.M. Diagnoses included infection/inflammation of implants/grafts, bacteremia, chronic kidney disease, diabetes, atrial fibrillation, hypertension, and depression. She was discharged on [DATE]. Review of the hospital admission orders dated 10/26/23 revealed Resident #99 was to receive intravenous (IV) piperacillin-tazobactam 4.5 grams every 12 hours with an end date of 12/04/23. Review of the progress notes dated 10/26/23 at 5:00 P.M. revealed Resident #99 was admitted to the facility and had a graft site to the left lower arm and refused to allow staff to remove the bandage. Review of the physician's orders revealed Resident #99 had an order for IV piperacillin-tazobactam 4.5 grams every 12 hours dated 10/27/23. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #99 had intact cognition. Review of the October 2023 MAR revealed Resident #99 did not receive her first dose of IV piperacillin-tazobactam 4.5 grams every 12 hours until 6:00 A.M. on 10/28/23, which was almost 37 hours after admission. Review of the facility emergency IV kit revealed they had two vials of 2.25-gram Piperacillin Sod-Tazobactam IV solution in stock. On 12/06/23 at 2:30 P.M. an interview with the Director of Nursing (DON) revealed she had looked everywhere and even called pharmacy but she did not know why Resident #99 did not receive her first dose of IV antibiotic. She stated it looked like it was given on 10/27/23 at 6:00 P.M. She stated she was not the DON at that time and did not know the resident. On 12/07/23 at 3:26 P.M. an interview with Registered Nurse #155 revealed if he documented a nine on the MAR for 11/27/23 at 6:00 P.M. then the medication was not available to give. He stated he did not have the medication to administer to Resident #99 and he believed he looked in the house stock kit and it was not available in there either. This deficiency represents non-compliance investigated under Complaint Number OH00148265.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record and interview with the staff the facility failed to maintain a medication error rate of less than five percent. The medication error rate was calculated to be 13.3 percent and included four medication errors of 30 opportunities for error. This affected one resident (Resident #55) out of four residents observed during medication administration. The facility census was 97. Findings include: Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, COVID-19, hypoxemia, polyneuropathy, chronic kidney disease, benign prostatic hyperplasia, Alzheimer's disease, glaucoma, abdominal aortic aneurysm, atrial fibrillation, adult failure to thrive, weakness, cognitive communitive deficit, and major depressive disorder. Review of the Significant Change Minimum Data Set 3.0 assessment dated ,d+[DATE] revealed Resident #55 had intact cognition. Review of the December 2023 physician's orders revealed Resident #55 had orders for aspirin 81 milligram (mg), multivitamin with minerals, calcium citrate 250 mg, brimonidine tartrate timolol maleate 0.2/0.5 percent ophthalmic drops, Combivent Respimat 20/100 micrograms (mcg), diltiazem 120 mg, Lasix 40 mg, vitamin B12 1000 mcg, losartan 25 mg, and requip 4 mg in the morning. Observation of medication administration on 12/04/23 at 9:45 A.M. revealed Licensed Practical Nurse #100 had begun to prepare the medication for Resident #55. She prepared one tablet of requip 4.0 milligrams (mg), half a tablet of losartan 25 mg, one table of calcium 600 mg with vitamin D 400 mg, one tablet of aspirin 81 mg, one tablet of multivitamin, one tablet of vitamin B12 1000 microgram (mcg), brimonidine tartrate timolol maleate 0.2/0.5 percent ophthalmic drops, and Combivent Respimat 20/100 mcg. She stated he had orders for one tablet of Lasix 40 mg and one tablet of diltiazem 120 mg however they were not in the medication cart so she had to go pull them from the house stock. She placed all the medications for Resident #55 in the top drawer of the medication cart and went to pull the two medications from stock. When she came back from getting the Lasix and diltiazem, she retrieved the medications from the top drawer of her medication cart and went into the room of Resident #55. She never retrieved the brimonidine tartrate timolol maleate 0.2/0.5 percent ophthalmic drops and Combivent Respimat 20/100 mcg and she never rechecked the orders in the computer to make sure she had everything. The nursing assistants were finishing up resident care so she had to wait a few minutes to administer the medications. When they were finished with his care LPN #100 administered the medications to Resident #55 minus the brimonidine tartrate timolol maleate 0.2/0.5 percent ophthalmic drops and Combivent Respimat 20/100 mcg. She left the room and went out to the medication cart and signed off all of his medication in the computer including the brimonidine tartrate timolol maleate 0.2/0.5 percent ophthalmic drops and Combivent Respimat 20/100 mcg, she then moved on to administer medication to Resident #5. These medication errors caused the medication error rate to be 13.3 percent. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/04/23 at 10:11 A.M. an interview with LPN #100 verified she had not administered the brimonidine tartrate timolol maleate 0.2/0.5 percent ophthalmic drops and Combivent Respimat 20/100 mcg. She stated she forgot them in the top of the medication cart. She also verified his orders were for multivitamin with minerals and Calcium Citrate 250 mg and she administered a plain multivitamin and Calcium 600 mg with vitamin D 400 mg. This deficiency represents non-compliance investigated under Complaint Number OH00148265.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record and interviews with staff the facility failed to ensure a clean sanitary environment while providing resident care to Resident #55 and during a dressing change for resident #78. This affected two residents (Resident #55 and #78) of three residents reviewed for infection control. The facility census was 97. Findings include: 1. Review of the medical record revealed Resident # 78 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, anemia, acute cystitis, severe protein calorie malnutrition, encephalopathy, diabetes, diabetic neuropathy, cognitive communication, hemiplegia, gastrostomy, and weakness. Review of the Five-Day Medicare Minimum Data Set (MDS) 3.0 assessment dated [DATE] Resident #78 had moderately impaired cognition, he had a tube feed for nutrition and received insulin. Review of the December 2023 physician's orders revealed Resident #78 had an order to cleanse his sacral wound with normal saline, apply hydrogel and silver alginate, cover with border foam every day, and as needed. Observation of wound care on 12/06/23 at 10:20 A.M. revealed Registered Nurse (RN) #120 provided wound care to Resident #78. She gathered all her supplies in the hallway from her treatment cart. She took them into the room and placed them directly on the over the bed table without sanitizing the stand or placing a barrier down. The resident's cell phone and the television remote were still on the over the bed table. She put on gloves without washing her hands first. She opened the prepackaged four by four gauze and opened the ampule of normal saline and pre moistened the four-by-four gauze. She helped raise the bed with the bed control remote and helped reposition him on his right side in bed. She removed the old dressing which was dated 11/05, she stated the nurse must have written the wrong date down. She removed the old dressing and threw it into the trash bag. She picked up the four-by-four moistened gauze and cleaned the sacral wound of Resident #78. She discarded the soiled gauze in the trash and picked up the closed dressing of silver calcium alginate and was unable to open it with her soiled gloves on so she took off her gloves and opened the sliver calcium alginate and collagen wound dressing package with her bare hands. She put on gloves which were laying directly on his over the bed table and picked up the sliver calcium alginate and collagen wound dressing package and placed them directly on his sacral wound and covered the wound and dressing with a border foam dressing. She cleaned up all the dressing supplies and threw them into the trash, she took off her gloves and washed her hands. On 12/06/23 at 10:35 A.M. an interview with RN #120 revealed she had not washed her hands after she entered the room, she touched the bed control remote and helped reposition the resident without washing her hands or donning new gloves. She also verified she had not washed her hands after cleaning the wound and before placing the new dressing. She stated she had put on a new pair of gloves though. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, COVID-19, hypoxemia, polyneuropathy, chronic kidney disease, benign prostatic hyperplasia, Alzheimer's disease, glaucoma, abdominal aortic aneurysm, atrial fibrillation, adult failure to thrive, weakness, cognitive communitive deficit, and major depressive disorder. Review of the Significant Change MDS 3.0 assessment dated ,d+[DATE] revealed Resident #55 had intact cognition. Observation on 12/04/23 at 9:55 A.M. revealed Licensed Practical Nurse (LPN)#100 went into the room of Resident #55 to administer medications. State tested Nursing Assistant (STNA)# 110 and STNA# 113 were providing incontinence care to Resident #55. There was wet and soiled bed linen directly lying the floor. STNA #113 picked them up and placed them into a plastic bag. They proceeded to change his lift sheet and pad from under him when STNA #113 tossed the soiled lift sheet and pad directly unto the floor beside his bed. She then placed a clean lift sheet under him. She picked the soiled linens up off the floor a placed them into the plastic bag with the rest of the soiled linens. On 12/04/23 at 10:01 A.M. an interview with LPN #100 revealed they were not to place soiled linens directly on the floor. This deficiency represents non-compliance investigated under Complaint Number OH00148265.