

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Greenbriar Community Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48912</p> <p>Based on interviews and record review the facility failed to ensure services were provided by the facility to meet quality professional standards. The facility failed to ensure a medication was transcribed properly for 1 (#153) of 33 sampled residents.</p> <p>Findings:</p> <p>Review of Resident #153's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses which included Depression and Insomnia.</p> <p>Review of Resident #153's Psychoactive Gradual Dose Reduction Report dated 06/11/2024 revealed the following:</p> <p>1. Trazadone HCl 100mg give one tablet my mouth at bedtime.</p> <p>Further review revealed on 06/13/2024, S11NP selected a dose reduction was appropriate for Resident #153 and wrote a new order for Trazadone 50 mg HS.</p> <p>Review of Resident #153's active Physician Orders revealed the following:</p> <p>Start Date: 02/16/2024-Trazadone HCl 100 mg give one tablet by mouth at bedtime.</p> <p>Further review revealed no order for Trazadone 50 mg HS.</p> <p>Review of Resident #153's MAR dated June 2024 and September 2024 revealed the resident received Trazadone HCl 100mg po HS.</p> <p>On 09/16/2024 at 9:52 a.m., an interview was conducted with S10MR. She stated she was responsible for making sure Psychoactive Gradual Dose Reduction changes were inputted into the computer for implementation. She stated after the DON reviewed Psychoactive Gradual Dose Reduction reports, she received them and entered the changes into the computer. S10MR reviewed Resident #153's Psychoactive Gradual Dose Reduction report dated 06/11/2024 and Resident #153's active Physician's orders and confirmed she did not see the new order for Trazadone 50 mg HS and did not input it into the computer and stated she should have.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/16/2024 at 10:09 a.m., an interview was conducted with S3DON. S3DON stated medical records department was responsible for inputting Psychoactive Gradual Dose Reduction changes into the computer for implementation. S3DON reviewed Resident #153's Psychoactive Gradual Dose Reduction report dated 06/11/2024 and Resident #153's active Physician's orders and confirmed the new order for Trazadone 50 mg HS was not entered into the computer system and should have been.</p> <p>On 09/16/2024 at 11:11 a.m., a telephone interview was conducted with S11NP. She stated she expected staff to properly transcribe orders from the Psychoactive Gradual Dose Reduction reports. S11NP confirmed Resident #153 should have had a current order for Trazadone 50mg HS, not Trazadone HCl 100mg HS.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44615</p> <p>Based on observations, interviews and record review, the facility failed to ensure residents were free of significant medication errors for 1 (#87) of 2 (#82 and #87) residents reviewed during narcotic medication review. The deficient practice had the potential to effect the 165 residents residing in the facility receiving medications.</p> <p>Findings:</p> <p>Review of the facility's policy titled Medication Administration, dated 11/28/2017, revealed the following, in part:</p> <p>3.0 Procedure</p> <p>Prior to giving medication, regardless of the type of medication, always follow the six rights:</p> <ol style="list-style-type: none"> 1. Right Individual 2. Right medication 3. Right dose 4. Right time 5. Right route 6. Right documentation <p>Review of Resident #87's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Pain and Muscle Wasting and Atrophy.</p> <p>Review of Resident #87's Physician Orders dated September 2024 revealed the following, in part:</p> <p>Oxycodone HCL oral tablet 10 mg. Give 10 mg by mouth every 4 hours as needed for breakthrough pain. Order date: 09/03/2024.</p> <p>MS Contin oral tablet 15 mg. Give 15 mg by mouth two times a day for pain. Order date: 09/03/2024.</p> <p>Review of Resident #87's MAR dated 09/01/2024-09/30/2024 revealed the following, in part:</p> <p>Oxycodone HCL oral tablet 10 mg. Give 10 mg by mouth every 4 hours as needed for breakthrough pain. Order date: 09/03/2024.</p> <p>Given on 09/09/2024 at 3:57 p.m.</p> <p>Review of Resident #87's MAR dated 09/01/2024-09/30/2024 revealed the following, in part:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>MS Contin oral tablet 15 mg. Give 15 mg by mouth two times a day for pain. Order date: 09/03/2024.</p> <p>On 09/09/2024 at 4:03 p.m., an observation was conducted of medication Cart A1 with S8LPN. An observation was made of the narcotic medication sign out documentation for Resident #87. The MS Contin oral tablet 15 mg pill pack was counted and was noted to be missing 1 tablet. S8LPN stated Resident #87 was scheduled to receive MS Contin oral tablet 15 mg daily at 8:00 a.m. and 8:00 p.m. and a second narcotic, Oxycodone, could be given as needed every four hours. S8LPN stated she gave Resident #87 the wrong narcotic medication at 3:57 p.m. S8LPN stated she thought she administered Oxycodone, but had administered MS Contin instead.</p> <p>On 09/10/2024 at 4:00 p.m., an interview was conducted with S3DON. He stated S8LPN removed and administered Resident #87's scheduled MS Contin, instead of the PRN Oxycodone, on 09/09/2024 at 3:57 p.m. He stated this resulted in Resident #87 receiving MS Contin four hours earlier than the medication was scheduled to be administered. He confirmed S8LPN had not followed the 6 rights of medication administration and made a medication error.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44615</p> <p>Based on observation, interviews, and record review, the facility failed to ensure expired medications and biologicals were not available for use and administration to residents as evidenced by:</p> <p>Having expired medications for 1 (Cart B) of 4 (Cart A1, Cart A2, Cart B, and Cart F) reviewed for med storage.</p> <p>Findings</p> <p>Review of the facility's policy titled Medication Administration dated 11/28/2017 revealed the following:</p> <p>Procedure:</p> <p>Do not administer medications passed their expiration date.</p> <p>An observation was made on 09/09/2024 at 4:36 p.m. with S6CC and S7LPN of Cart B. The following was observed:</p> <p>1 bottle of eye drops with expiration date 07/2024;</p> <p>1 bottle of oral liquid Morphine with open date of 07/21/2024 and no expiration date.</p> <p>An interview was conducted with S7LPN on 09/09/2024 at 4:37 p.m. She stated she did not know why the expired medication bottles were in Cart B, but should have been removed. S7LPN verified liquid Morphine was administered on 09/09/2024 at 12:06 a.m. and was beyond expiration date.</p> <p>An interview was conducted with S6CC on 09/09/2024 at 4:40 p.m. She confirmed eye drops were expired and should have been removed from Cart B. She stated nurses were responsible for monitoring and checking the medication carts for expired medications.</p> <p>An interview was conducted with S4ADON on 09/09/2024 at 4:40 p.m. She confirmed the eye drops were beyond expiration date and should have been discarded. She stated it was the night nurses' responsibility to check carts for expired medications. She added all nurses were responsible for checking expiration dates prior to administering medications. S4ADON confirmed nursing staff had not removed expired medications and should have.</p> <p>An interview was conducted with S3DON on 09/10/2024 at 4:00 p.m. He stated each nurse who administers medications was responsible for checking expiration dates. He further stated the floor nurse was responsible for checking medication carts for expired medications. S3DON confirmed eye drops were expired, should have been discarded, and had not been.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44615</p> <p>Based on observation, interviews, and record review, the facility failed to store and prepare food under sanitary conditions. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Food was properly stored and labeled in the walk-in freezer of the facility's kitchen; 2. Food was properly stored and labeled in the walk-in refrigerator of the facility's kitchen; and 3. Food was properly stored and labeled in the walk-in food storage room of the facility's kitchen. <p>This deficient practice had the potential to affect 165 residents who were served meals from the facility's kitchen.</p> <p>Findings:</p> <p>Review of the facility's policy titled Food Receiving and Storage dated October 2017 revealed the following:</p> <p>8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (received and/or open date).</p> <p>During the initial tour of the facility's kitchen with S5DM on 09/09/2024 at 9:00 a.m., the following observations were made:</p> <p>Walk-In Freezer:</p> <p>1 large black, plastic bag unlabeled and undated containing 2 slabs of uncooked ribs.</p> <p>Walk-In Refrigerator:</p> <p>1 large plastic container of salad dressing opened and undated.</p> <p>Dry Storage Room:</p> <p>22 quart plastic container of potatoes, dated opened 08/28/2024. No discard by or expiration date labeled.</p> <p>16 ounce container of Ground Cinnamon opened and undated.</p> <p>An interview was conducted on 09/10/2024 at 12:45 p.m., S5DM verified the above observations and confirmed the facility failed to store foods under sanitary conditions. She confirmed all opened food products should be labeled with date it was opened and an expiration/discard date. She further stated she was responsible for ensuring staff complied with policy. She confirmed all previously cooked items, stored in refrigerator should be discarded in 3-4 days.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 09/10/2024 at 1:05 p.m. with S1ADM. S1ADM confirmed all food storage items should be labeled, checked for both opened and expiration dates, and should not contain staff personal food items.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46975</p> <p>Based on observation, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment to help prevent the development and transmission of infection for 1 (#87) of 5 (#11, #82, #87, #94, and #146) residents reviewed for infection control. The facility failed to ensure staff wore proper Personal Protective Equipment (PPE) while providing care to a resident who was on Enhanced Barrier Precautions (EBP).</p> <p>Findings:</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions revised on 04/2024, revealed the following, in part:</p> <p>Policy Interpretation and Implementation</p> <p>2. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.</p> <p>3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include:</p> <p>g. device care or use</p> <p>Observation of the Enhanced Barrier Precautions sign posted on Resident #87's door revealed the following, in part:</p> <p>Providers and staff must also:</p> <p>Wear gloves and a gown for the following high-contact resident care activities.</p> <p>Device care or use: central line</p> <p>Review of Resident #87's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses of Surgical Site Infection and Long Term Current Use of Antibiotics.</p> <p>Review of Resident #87's current Physician Orders revealed the following, in part:</p> <p>Enhanced Barrier Precautions. Every shift for central line, chronic wound. Wear gown and gloves when providing high contact resident care.</p> <p>An observation was made on 09/10/2024 at 10:55 a.m. of S9LPN administering an IV antibiotic to Resident #87 through her PICC line. S9LPN was not wearing a gown during the use of the central line.</p> <p>An interview was conducted on 09/10/2024 at 12:02 p.m. with S9LPN. S9LPN verified Resident #87 was on EBPs. She confirmed she did not wear a gown when administering the IV antibiotic through Resident #87's PICC line and should have.</p> <p>(continued on next page)</p>

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/10/2024 at 1:14 p.m. with S3DON. S3DON confirmed per EBP guidelines, nurses should wear a gown when administering IV antibiotics through a resident's PICC line.		