STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365192	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Health Center	6455 Pearl Rd Parma Heights, OH 44130

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on record review, interview and review of a local police report, the facility failed to ensure resident requests were honored and residents were treated with respect and dignity at all times. This affected one (#120) of 10 sampled residents and two residents who participated in random interviews (#108 and #8). The facility census was 128. Findings include: 1. Review of Resident #120's medical records revealed an admitted [DATE]. Diagnoses included morbid obesity, need for personal care assistance, muscle weakness and difficulty walking. Review of Resident #120's care plan dated 02/01/24 revealed Resident #120 required assistance with activities of daily living (ADL) by one staff who performed all the care and was totally dependent for transfers. Resident #120 preferred to get up into her wheelchair between breakfast and lunch and preferred to lay down before dinner daily. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #120 had intact cognition and was dependent with toileting, bathing, personal hygiene and transfers. Interview on 07/31/24 at 5:15 A.M. with State tested Nursing Assistant (STNA) #213 revealed Resident #120 had requested assistance into bed sometime around 8:00 P.M. on 07/30/24 and no one had helped her. Around 10:00 P.M. the police arrived at the facility because Resident #120 contacted them stating she needed assistance back into bed. STNA #213 was unsure who the assigned aide was for Resident #120 and had assisted Resident #120 back into bed once the police arrived. Interviews on 07/31/24 at 5:15 A.M. with STNAs #213 and #239 revealed they were aware of some residents who had complained about staff being rude to them. Interview on 07/31/24 at 5:26 A.M. with Resident #108 revealed at times the staff was rude and short with him. Interview on 07/31/24 at 6:15 A.M. with Resident #8 revealed some staff were rude at times. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/31/24 at 11:13 A.M. with Resident #120 revealed on 07/30/24 she was assisted out of bed around 3:00 P.M. and at approximately 8:10 P.M. she asked a STNA for assistance back into bed (could not provide name of the STNA but a description of the STNA matched STNA #213). Resident #120 stated she had overheard the STNA talking with someone in the hall about having to put all the residents back into bed and at that time she asked the STNA to help her. The STNA became upset and stated, Why are you getting in my business? Resident #120 told the aide she wasn't getting in her business but had overheard her discussing putting residents back into bed and she needed help with that. The STNA told Resident #120 she was leaving and Resident #120 thought the STNA had left because several hours had passed and the STNA had not returned. Resident #120 was upset about not being helped back into bed and called her son who called the police. Resident #120 stated the police arrived sometime around 11:00 P.M. and she was assisted back into bed at that time. Interview on 08/01/24 at 11:25 A.M. with the Administrator and Director of Nursing (DON) revealed they contacted the local police and obtained a copy of the police report from 07/30/24. Review of local police report with the Administrator at the time of the interview revealed Resident #120's son called the police on 07/30/24 at 10:25 P.M. to report Resident #120 had been left in her wheelchair since 2:00 P.M. and had defecated on herself twice. The report indicated upon arrival at 10:27 P.M. Resident #120 was receiving care. Review of facility's undated policy Resident Rights revealed residents had the right to be treated with respect and the right to decide when to go to bed and rise. This deficiency represents non-compliance investigated under Complaint Number OH00154863.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review the facility failed to provide timely incontinence care. This affected four (#102, #115, #117, and #120) of six residents observed for incontinence care. The facility census was 128. Findings include: 1. Review of Resident #102's medical records revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, muscle weakness and need for personal care assistance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #102 had impaired cognition, was dependent with toileting, and was incontinent of bowel and bladder. Review of Resident #102's care plan dated 06/10/24 revealed Resident #102 was totally dependent for toileting. Resident #102 was incontinent of bowel and bladder and interventions included to check Resident #102 for incontinence. Interviews on 07/31/24 at 5:15 A.M. with State tested Nursing Assistant (STNA) #213 and STNA #239 revealed they were aware of residents who did not receive timely incontinence care; they observed residents who were soiled when they arrived to start their shifts at 7:00 P.M. Interview on 07/31/24 at 5:48 A.M. with STNA #214 revealed revealed she was aware of residents who did not receive timely incontinence care; STNA #214 observed residents who were soiled when she arrived to start her shifts at 7:00 P.M. Observation on 07/31/24 at 6:30 A.M. revealed Resident #102 was in a wheelchair in his room and his pants were wet. Interview with Resident #102 at time of observation revealed he was unable to answer questions appropriately and he was not sure if his pants were wet. At the time of the observation STNA #239 and Licensed Practical Nurse (LPN) #235 entered Resident #102's room and confirmed Resident #102's pants were wet. LPN #235 and STNA #239 transferred Resident #102 into bed and further observation revealed Resident #102's wheelchair had a puddle of urine on the seat. STNA #239 stated he was not the assigned STNA for Resident #102 and he did not know which STNA was assigned to his care. Interview on 07/31/24 at 6:50 A.M. with STNA #262 revealed she was assigned to Resident #102 at 3:00 A.M. and she was unaware Resident #102 needed incontinence care and was unable to state when he had last been checked and/or changed for incontinence. 2. Review of Resident #115's medical records revealed an admitted [DATE]. Diagnoses included intellectual disabilities, muscle weakness and contractures. Review of the MDS assessment dated [DATE] revealed Resident #115 was rarely understood, dependent with toileting and was incontinent of bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 06/16/24 revealed Resident #115 was totally dependent for toileting. Resident #115 was incontinent of bowel and bladder. Interviews on 07/31/24 at 5:15 A.M. with State tested Nursing Assistant (STNA) #213 and STNA #239 revealed they were aware of residents who did not receive timely incontinence care; they observed residents who were soiled when they arrived to start their shifts at 7:00 P.M. Interview on 07/31/24 at 5:48 A.M. with STNA #214 revealed revealed she was aware of residents who did not receive timely incontinence care; STNA #214 observed residents who were soiled when she arrived to start her shifts at 7:00 P.M. Observation on 07/31/24 at 8:33 A.M. revealed Resident #126 was in the hallway yelling that her roommate, Resident #115, had not been changed all night. Interview with Resident #126 at the time of the observation revealed Resident #115 had not received incontinence care since sometime yesterday and she had an odor of bowel movement. Observation of incontinence care on 07/31/24 at 8:55 A.M. for Resident #115 with STNA #330 and STNA #358 revealed Resident #115 was saturated with urine and stool that had soaked through her incontinence brief and bed sheets onto her mattress. STNAs #330 and #358 stated they had not provided care for Resident #115 since they started their shift at 7:00 A.M. and were not sure when Resident #115 had last been changed. Resident #115 was not interviewable. 3. Review of Resident #117's medical records revealed an admitted [DATE]. Diagnoses included cognitive deficits, tracheostomy, need for personal care assistance and muscle weakness. Review of the MDS assessment dated [DATE] revealed Resident #117 was rarely understood, dependent with toileting and was incontinent of bowel and bladder. Review of the care plan dated 05/02/24 revealed Resident #117 was totally dependent for toileting. Resident #117 was incontinent of bowel and bladder. Interviews on 07/31/24 at 5:15 A.M. with State tested Nursing Assistant (STNA) #213 and STNA #239 revealed they were aware of residents who did not receive timely incontinence care; they observed residents who were soiled when they arrived to start their shifts at 7:00 P.M. Interview on 07/31/24 at 5:48 A.M. with STNA #214 revealed revealed she was aware of residents who did not receive timely incontinence care; STNA #214 observed residents who were soiled when she arrived to start her shifts at 7:00 P.M. Observation of incontinence care on 07/31/24 at 8:05 A.M. for Resident #117 with STNAs #230 and #293 revealed Resident #117 was incontinent of a large amount of urine that had soaked through his bed sheets and to his mattress. STNA #230 stated she had not provided incontinence care for Resident #117 since she had started her shift at 7:00 A.M. and was unable to state when he had last been checked and/or changed for incontinence. Resident #117 was not interviewable. 4. Review of Resident #120's medical records revealed an admitted [DATE]. Diagnoses included need for personal care assistance, muscle weakness and morbid obesity. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment dated [DATE] revealed Resident #120 had intact cognition. Resident #120 was dependent for toileting, and was incontinent of bowel and bladder. Review of the care plan dated 05/10/24 revealed Resident #120 was totally dependent for toileting. Resident #120 was incontinent of bowel and bladder. Interviews on 07/31/24 at 5:15 A.M. with State tested Nursing Assistant (STNA) #213 and STNA #239 revealed they were aware of residents who did not receive timely incontinence care; they observed residents who were soiled when they arrived to start their shifts at 7:00 P.M. Interview on 07/31/24 at 5:48 A.M. with STNA #214 revealed revealed she was aware of residents who did not receive timely incontinence care; STNA #214 observed residents who were soiled when she arrived to start her shifts at 7:00 P.M. Interview on 07/31/24 at 11:13 A.M. with Resident #120 revealed she had last been changed at approximately 11:00 P.M. the previous evening. Observation of incontinence care on 07/31/24 at 11:23 A.M. for Resident #120 with STNA #358 revealed Resident #120 had been incontinent of a large amount of urine and stool that had soaked through her incontinence brief, her sheets and to her mattress. Interview with STNA #358 revealed she had not provided incontinence care for Resident #120 since her shift began and she did not know the last time she had received toileting assistance or was checked/changed. This deficiency represents non-compliance investigated under Complaint Number OH00154863.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42733 Based on observation and interview the facility failed to ensure a clean and sanitary environment. This affected two (#67 and #117) of five random residents whose rooms were observed. The facility census was 128. Findings include: Observation on 07/31/24 at 8:05 A.M. with State tested Nursing Assistant (STNA) #230 and STNA #293 revealed two soiled incontinence briefs on Resident #117's wheelchair with gnats flying around them. Interview with STNA #230 at time of observation revealed when she entered Resident #117's room the incontinence briefs were on the floor and she had picked them up and placed them on Resident #117's wheelchair. Observation on 07/31/24 at 9:09 A.M. revealed a large pile of dirty linens on the floor of Resident #67's room with a foul odor detected. Interview with Resident #67 at time of observation revealed the dirty linens had been on the floor since last night when they changed his bed. The observation was confirmed by STNA #330 who indicated she would dispose of the linens. This deficiency represents non-compliance investigated under Complaint Number OH00154863.