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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER: Greenbrier Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on medical record review, interviews and policy review the facility failed to ensure effective discharge planning was in place for two residents (Residents #125 and #126) of three residents reviewed for discharge planning. The facility census was 123. Findings include: 1. Review of the closed medical record for Resident #125 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to diabetes mellitus with neuropathy, spondylosis, psychoactive substance abuse, and vascular dementia. Review of Resident #125's care plan revealed it was last reviewed on 04/2024 and stated the resident had no plans for discharge to the community. Review of Resident #125's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #125 used a walker and required supervision for ADLs. The assessment noted there was no plan for discharge. Review of Resident #125's MDS 3.0 discharge assessment dated [DATE] revealed a BIMS score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #124 was independent for ADLs. The assessment noted active plans to discharge, but a referral had been declined. Review of Resident #125's nursing progress notes revealed a note dated 12/04/24 timed at 5:47 P.M. revealed Resident #125 discharged with family, medications, orders and belongings were sent and report was called to the new facility. Further review of Resident #125's progress notes revealed no other recorded notes related to discharge planning prior to the note dated 12/04/24. Review of the 12/04/24 discharge summary for Resident #125 revealed the resident was being discharged to an assisted living facility. Interview on 02/11/25 at 2:26 P.M. with Social Worker #509 confirmed she had not documented any changes to discharge planning in the medical record and had not updated the care plan for Resident #125. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the closed medical record for Resident #126 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to spastic quadriplegic cerebral palsy, contracture of left lower leg, pseudobulbar affect, anxiety disorder, seizures, paralytic gait, depression, suicidal ideations, and history of traumatic brain injury. Review of Resident #126's discharge care plan revealed it was last revised on 10/16/24 with no noted plans for discharge. Review of Resident #126's MDS 3.0 quarterly assessment dated [DATE] revealed a BIMS score of 14 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #126 required moderate to maximum assistance for ADLs. The assessment noted there was no plan for discharge. Review of Resident #126's MDS 3.0 discharge assessment dated [DATE] revealed a BIMS score of 14 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #126 required moderate to maximum assistance from staff. Active discharge planning was noted. The assessment referenced contact with a local agency was not made due to unknown place of discharge. Review of the social services progress notes dated 02/01/25 timed at 11:09 A.M. revealed Social Worker (SW) # 509 received electronic mail contact from Abuse Counselor #513 stating Resident #126 wanted to discuss discharge possibility to move out of state to South Carolina (SC) to be closer to family. Abuse Counselor #513 had contacted SC Medicaid agency and was advised that Resident #126 was unable to apply for Medicaid until he was physically in the state of SC. Abuse Counselor #513 was able to secure a plane flight and transportation through American Disability Act (ADA) to provide Resident #126 a supervised flight to SC. Resident #126's father was going to pick him up at the airport and take him to a local hospital (name not specified) to start the process to transfer his Medicaid services and find placement at a local skilled nursing home facility. Social Worker #509 was going to follow Resident #126's transport to the airport and check Resident #126 in at the airport to initiate ADA assistance for his flight. Review of nursing progress note dated 02/01/25 timed at 1:49 P.M. revealed Resident #126 was picked up and discharged . Social worker accompanied Resident #126 to the airport. Resident #126 left with medications, physician orders and belongings. No additional progress notes were found related to discharge planning. Review of discharge summary dated 01/31/25 for Resident #126 revealed a discharge date of [DATE]. Resident #126's discharge status was noted to be home under care of organized home health service with written medication list provided, Resident #126 noted to fly home to South Carolina to be with family. Resident #126's father was planning to meet resident at the airport and take him to a (non-specified) hospital to initiate care in another state and the Medicaid process. Resident's plane flight was set up with American's Disability Act (ADA) compliance and patient was to be supervised through any waiting periods until his father picked him up in SC. Resident #126 was noted to be able to make needs known and sometimes required assistance to read materials. (continued on next page)

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Greenbrier Health Center	6455 Pearl Rd Parma Heights, OH 44130

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/11/25 at 8:41 A.M. with Social Worker #509 revealed Resident #126 was working with Abuse Counselor #513 who made her aware on 12/31/24 of Resident #126's request to move to SC to be closer to family. Abuse Counselor #513 told her she had reached out to Medicaid in South Carolina and was told Resident #126 was unable to start Medicaid benefit transfer until he was physically in the state of SC and was advised to have Resident #126 go to a local hospital to start the Medicaid process. Abuse Counselor #513 arranged for the plane flight with ADA assistance, and Resident #126's father to pick him up at the airport in SC and take him to a local hospital to initiate transfer of Medicaid benefits. SW #509 followed the transport vehicle to the airport, and she assisted to check Resident #126 in at airport security until ADA assistance for the flight was initiated. Phone interview on 02/11/25 at 10:05 A.M. with Abuse Counseling Manager (ACM) #510 revealed Abuse Counselor #513 was out sick at the time of the interview but was familiar with Resident #126's case. ACM #510 stated Resident #126 had expressed desire to move back to SC back in June or July of 2024 and the agency had been working with Resident #126 since then to secure paperwork and the necessary funds to move back to SC. Resident #126 was able to pay for his plane ticket and the associated transportation and ADA supervision fees with his personal account. Abuse Counselor #513 had previously spoken to a local Medicaid office in SC who instructed her until Resident #126 was physically present in SC, his benefits were unable to be transferred. The Medicaid office had encouraged Abuse Counselor #513 to have Resident #126 taken to a local hospital to initiate Medicaid benefit transfer. Abuse Counselor #513 arranged for ADA supervised assistance from check in at the airport until being picked up in SC. Abuse Counselor #513 also spoke with Resident #126's father who agreed to pick Resident #126 up at the airport and take him to a hospital. Phone interview on 02/11/25 at 10:25 A.M. with SC Medicaid Representative #511 confirmed in order to receive Medicaid benefits, the person needs to be physically present and have a permanent address in the state of SC. If the person was receiving benefits in another state, they would need to request a termination letter and provide proof benefits are no longer being received in the previous state. SC Medicaid Representative #511 stated if a person was trying to establish benefits in SC, they would need to be physically present in the state. If individuals are unable to care for themselves, they could go to a local hospital to initiate the process to transfer Medicaid benefits. Phone interview on 02/11/25 at 10:56 A.M. with Resident #126's father confirmed he had spoken with Abuse Counselor #513 towards the end of December 2024 on the phone and had agreed to pick up Resident #126 at the airport and take him to a local hospital. Resident #126's father stated he was unable to take care of Resident #126 and had not been asked by the former facility or anyone else to assist with looking for a potential long-term care facility near him (in SC). Resident #126's father confirmed he had picked up Resident #126 at the airport on 02/01/25 and had taken him to a local hospital where he remained as of 02/11/25. Resident #126's father also confirmed he had his motorized wheelchair and will take it to wherever Resident #126 is placed for long term care. Interview on 02/11/25 at 2:26 P.M. with SW #509 confirmed she had spoken with Resident #126 about his discharge but had not entered any progress notes related to their conversations or conversations with Abuse Counselor #513 prior to the day of Resident #126's discharge. SW #509 also confirmed Resident #126's care plan had not been updated since discharge process was initiated and the social work section of the Discharge Summary dated 01/31/25 for Resident #126 did not list the name of the hospital where Resident #126 was going nor any potential facilities for placement. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/11/25 at 3:21 P.M. with the Administrator confirmed when a resident expresses interest in discharge, updates will be noted in the medical record and the care plan should be updated to reflect changes. Review of the undated facility policy Transfer and Discharge Policy revealed when a resident discharge is anticipated, facility will develop and implement a discharge plan that focuses on the resident's discharge goals, the preparation of resident to be active partners and effectively transition them to post discharge care and the reduction of factors leading to the preventable readmissions. The discharge plan will include regular re-evaluation of residents to identify changes that required modification of the discharge plan. The discharge plan will be updated, as needed, to reflect these changes. Facility will document that a resident has been asked about their interest in receiving information regarding returning to the community. If the resident indicates an interest in returning to the community, the facility will document any referrals to local contact agencies or other appropriate entities made for this purpose. The facility will assist resident and their resident representative in selecting a post-acute provider by using data that is relevant and applicable to the resident's goals of care and treatment preferences. The post discharge plan of care will indicate where the individual plans to reside, arrangements that have been made for the resident's follow up care and post discharged medical and non-medical services. This deficiency represents non-compliance investigated under Complaint Number OH00162430.