

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Greenbriar Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810</p> <p>Based on observation, interview, record review, and review of the facility policy the facility failed to ensure Resident #48, who had an order to self-medicate, kept his medications stored appropriately. This affected one resident (#48) who the facility identified as the only resident in the facility that self-medicated. The facility census was 92.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, hypertension, and schizophrenia.</p> <p>Review of the physician's order dated 06/12/24 revealed that Resident #48 may keep his medications at his bedside and administer his medications to himself.</p> <p>Review of the self-administration of medication assessment dated [DATE] revealed that Resident #48 demonstrated secure storage for medication in his room.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #38 had intact cognition. Resident #48 required minimal assistance with all activities of daily living.</p> <p>Review of the care plan dated 09/18/24 revealed Resident #48 prefers to administer his own medication. Interventions included assist Resident #48 in securing his medication after administration, and to educate him on proper storage of the medications to prevent unauthorized access.</p> <p>Interview on 09/25/24 at 9:50 A.M. with Resident #48 revealed he had no concerns with his medications because he administered them to himself. He reported he gets his medications prefilled from a local pharmacy and he keeps them in his room and gives them to himself. Resident #48 reported he does not have a lock box for his medications because he does not need one. Observation during the interview revealed a cardboard box sitting in a paper bag next to his bed with Resident #48's information on it full of prefilled packets for administration. The outside of the box listed the medications inside and they included:</p> <p>Coreg 3.125 milligrams (mg) (medication to treat high blood pressure)</p> <p>Metformin 500 mg (medication to treat diabetes)</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Lisinopril 10 mg (medication to treat high blood pressure and heart failure)</p> <p>Prilosec 20 mg (medication to treat heartburn, a damaged esophagus, stomach ulcers, and gastroesophageal reflux disease)</p> <p>Lasix 40 mg (diuretic)</p> <p>Multivitamin tablets (supplement)</p> <p>Vitamin D3 5000 units (supplement)</p> <p>Colesevelam 625 mg (medication to treat high cholesterol and type two diabetes)</p> <p>Atorvastatin 10 mg (medication to treat high cholesterol and triglyceride levels)</p> <p>Jardiance 10 mg (medication to help lower blood sugar levels and treat type two diabetes)</p> <p>Interview on 09/25/24 at 11:20 A.M. with the Director of Nursing (DON) confirmed Resident #48's medications were not locked in storage. He reported Resident #48 was instructed to keep his medications in his drawer which did not have a lock.</p> <p>Interview on 09/25/24 at 11:50 A.M. with the Regional Nurse #504 confirmed Resident #48 did have his medications unlocked in his room because he removed the lock from his drawer.</p> <p>Review of the undated facility policy titled Resident Self-Administration of Medication revealed assessments will include addressing the following and documenting in the care plan to include storage of the medication.</p> <p>Review of the facility policy titled Storage of Medications, revised August 2020, revealed the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts and medication supplies are locked when they are not attended by persons with authorized access.</p> <p>This deficiency is an incidental finding identified during the complaint investigation.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810</p> <p>Based on observation, interview, record review, and facility policy review the facility failed to administer medications to Resident #31 in accordance with professional standards of practice. This affected one resident (#31) of two residents observed for medication administration. The facility census was 92.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, type two diabetes mellitus, chronic obstructive pulmonary disease, and peripheral vascular disease.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had intact cognition. Resident #31 required extensive assistance for all activities of daily living and had an indwelling urinary catheter and was always incontinent of bowel.</p> <p>Review of the care plan dated 08/14/24 revealed Resident #31 required assistance with all activities of daily living. Interventions included to provide set up and clean up assistance for eating and to provide supervision and touching assistance for oral hygiene.</p> <p>Observation of medication administration on 09/25/24 at 8:20 A.M. with Licensed Practical Nurse (LPN) #503 revealed she filled a medication cup with:</p> <p>Norvasc 10 milligrams (mg) tablet (a medication to treat high blood pressure and chest pain)</p> <p>Aspirin 81 mg tablet (blood thinner)</p> <p>Bumex 2 mg tablet (a medication to treat fluid retention and high blood pressure)</p> <p>Clonidine 0.1 mg tablet (a medication to treat high blood pressure)</p> <p>Losartan 25 mg tablet (a medication to treat high blood pressure)</p> <p>Vitamin D 25 micrograms (mcg) tablet (supplement)</p> <p>Sodium bicarbonate 500 mg tablet (a medication used to treat heartburn, sour stomach, and acid indigestion)</p> <p>Isosorbide 30 mg tablet 9a medication to treat chest pain)</p> <p>Cilostazole 25mg tablet (vasodilator)</p> <p>Coreg 25 mg tablet (a medication to treat high blood pressure and heart failure)</p> <p>Colace 100 mg tablet (stool softener)</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Iron 65 mg tablet (supplement)</p> <p>Symbicort inhaler (medication to treat asthma and chronic obstructive pulmonary disease)</p> <p>LPN #503 entered the room for Resident #31. She administered two puffs of the inhaler to Resident #31 and then encouraged him to rinse his mouth. Resident #31 had hand contractures and did not grab his water. LPN #503 then immediately handed the medication cup with the 12 tablets and instructed Resident #31 to take his medications. Resident #31 threw all 12 tablets into his mouth. LPN #503 then immediately left the room and went into the hallway to her medication cart out of sight of Resident #31. Resident #31 struggled to grab his glass of water and began to attempt to swallow his medications. Resident #31 then began to take sips of water and struggled and coughed to get his medications down. Resident #31 stated after he swallowed his pills wow that was tough.</p> <p>Interview on 09/25/24 at 8:25 A.M. with LPN #503 confirmed she did not watch and ensure Resident #31 swallowed all his pills safely. She reported that she also did not ensure Resident #31 rinsed his mouth after administering his inhaler.</p> <p>Review of the undated facility policy titled Medication Administration revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care. It revealed all inhaled medications residents will rinse mouth after steroid inhaler. It also revealed that nurses must remain with the resident until the medication has been swallowed.</p> <p>This deficiency is an incidental finding identified during the complaint investigation.</p>