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	11/19/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 22653 Based on observation, medical record review, and interview, the facility failed to develop and implement comprehensive, effective and individualized pain management programs for all residents. The facility failed to ensure Resident #104 received pain medication as ordered and the facility failed to ensure Resident #60 was re-assessed timely following complaints of severe pain to determine if changes were needed to his medication regimen. This affected two residents (#60 and #104) of six residents reviewed for pain. Actual harm occurred on 11/14/24 when Resident #104, who had a diagnosis of metastatic (cancer cells have spread to areas other than the original tumor) lung cancer did not receive routine/scheduled pain medication as ordered to achieve effective pain relief/pain management and prevent shortness of breath resulting in complaints of increased pain which included facial grimacing and shortness of breath with pursed lip breathing. Findings include: 1. Review of Resident #104's medical record revealed the resident had diagnoses including malignant neoplasm of the lungs and chronic obstructive pulmonary disease. On 11/13/24 (at 8:00 P.M.) a new order was written for the administration of Morphine Sulfate (an opiate (narcotic) analgesic) 15 milligrams (mg) every four hours for metastatic lung cancer. Review of the medication administration record (MAR) revealed the 8:00 P.M. dose on 11/13/24 was not administered because Resident #104 was sleeping. In addition, the 12:00 A.M. and 4:00 A.M. doses of Morphine were not administered on 11/14/24 with a code to see nursing notes. However, the notes were devoid of a reason the medication was not administered. (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 0697 Level of Harm - Actual harm Residents Affected - Few	On 11/14/24 at 8:50 A.M., Resident #104's call light was observed on. The length of time it had been on was unknown at that time. At 8:55 A.M., Resident #104 ambulated to his doorway and spoke to Licensed Practical Nurse (LPN) #240 about getting pain medication. LPN #240 stated she was told Resident #104 did not receive pain medication over night or his morning doses because he was sleeping which Resident #104 denied. LPN #240 stated she would be with Resident #104 when she was done (preparing medication for another resident). At 8:57 A.M., Resident #104 had returned to his room and was sitting on the side of his bed. An interview with Resident #104 at the time of the observation revealed concerns he was having trouble getting his Morphine, stating he was supposed to get it every four hours. Resident #104 stated he had received no Morphine since 9:00 P.M. on 11/13/24. Pursed lip breathing, shortness of breath and facial grimacing were noted. Resident #104 stated the night nurse told him the facility was out of the Morphine. LPN #240 administered Resident #104's medication at 9:05 A.M. including the Morphine 15 mg. An interview on 11/14/24 at 9:09 A.M. with LPN #240 verified Resident #104's Morphine was scheduled every four hours. The last dose was signed out on the narcotic count sheet on 11/13/24 at 6:08 P.M. and she stated the Morphine was ordered for shortness of breath for terminal cancer. Further interview with Resident #104 on 11/14/24 at 9:10 A.M. revealed he was ordered the Morphine for both pain and shortness of breath. Resident #104 rated his pain an eight on a scale of zero to 10 with 10 being the most severe pain. On 11/14/24 at 11:55 A.M., Resident #104 stated he had received little relief from the Morphine administered that morning. His breathing continued to be labored and he rated his pain a six on a scale of zero to ten at that time. On 11/14/24 at 9:45 A.M., an interview with Registered Nurse (RN) #350 revealed he investigated the concern related to Resident #104's Morphine Sulfate administration. RN #350 verified the Morphine Sulfate was not administered in accordance with the physician's order and stated the nurses did not seem to understand when pain medication was ordered on a routine basis that it was necessary to offer it to maintain effective pain control even if a resident was sleeping. On 11/14/24 at 3:40 P.M., Nurse Practitioner (NP) #300 verified the order for Morphine indicated it was to be administered every four hours routine, not while awake or as necessary. The NP revealed attempts had been made to administer the Morphine while awake in the past and it was not effective and the NP indicated it was better to administer the medication around the clock. NP #300 stated it would take a while now for Resident #104 to obtain relief since he had not received the Morphine as ordered and that was why she wanted him to have it on a routine basis. When observations of purse lip breathing were shared with NP #300 she stated that could have been due to his respiratory status alone. Observations of facial grimacing were shared with no additional information/explanation provided. On 11/18/24 at 9:10 A.M., an interview with Hospice Nurse #270 revealed Resident #104's pain medication had been increased because he wasn't getting it routine and he had to wait when he asked for pain medication ordered on an as necessary (prn) basis. Hospice Nurse #270 revealed Resident #104 would not ask consistently for the as needed (prn) pain medication because he did not want to bother staff. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2. Review of Resident #60's medical record revealed diagnoses including osteoarthritis of both hips and osteonecrosis of the left femur (death to the bone that occurs when there is a disruption of blood supply to the thigh bone and could result in destruction of the hip joint and severe arthritis). On 11/01/24 an order was written for the pain medication Ultram 50 mg every eight hours as needed (prn) for pain. Review of the November 2024 MAR revealed pain severity levels recorded with prior administration of Ultram ranged from zero to ten with only one dose on 11/03/24 at 9:28 A.M. being ineffective. Review of the controlled drug administration record revealed the last dose was removed on 11/13/24. The time was difficult to read but appeared to be between 8:00 P.M. and 10:00 P.M. On 11/14/24 at 8:00 A.M., LPN #200 was observed conversing with Resident #60 when she entered his room to administer his medication. Resident #60 was in the bathroom and complained he had been in pain all night. LPN #200 responded the night nurse had reported when she went to administer Resident #60's pain pill the previous night he was sleeping so she and another nurse had to waste it. There were no more Ultram (pain pills) in the cart as the last dose had been wasted LPN #200 stated the Nurse Practitioner (NP) was supposed to be later (on this date) and would address the pain. When Resident #60's medication was administered on 11/14/24 at 8:34 A.M. and included gabapentin 200 milligrams (anticonvulsant which could be used for neuropathic pain) and Naproxen 250 milligrams (anti-inflammatory medication). On 11/14/24 at 11:58 A.M., interview with Resident #60 revealed he rated his pain at an 11 (on a scale of zero to 10). Resident #60 stated he had received Norco at the hospital and it was effective. Resident #60 stated he had discussed this with staff (could not provide names) but it had not been ordered yet. An interview with LPN #200 on 11/14/24 at 12:10 P.M. verified she had not reassessed Resident #60 to determine if his routine medication had been effective in relieving pain. LPN #200 verified she had not seen the nurse practitioner visit yet that day but stated Resident #60's Ultram was supposed to be delivered with medications that night. The November MAR indicated Resident #60 was provided 650 mg of acetaminophen on 11/14/24 at 12:40 P. M. for pain rated at ten on a scale of 0-10. The MAR indicated the acetaminophen was ineffective. On 11/14/24 at 3:40 P.M., NP #300 stated Resident #60 did not generally complain of pain when she visited. Resident #60's Gabapentin had been increased recently and staff were monitoring effectiveness. NP #300 stated Norco (pain medication) probably would be more effective if it had been effective when used previously. On 11/14/24, an order was written for hydrocodone/acetaminophen (Norco a narcotic pain medication) 5/325 mg one tablet every eight hours as needed (prn) for pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 11/18/24 at 10:38 A.M., Resident #60's facial expressions were noted to be more relaxed. Resident #60 stated he had been receiving Norco over the weekend and stated he was feeling great. Resident #60 stated he was sleeping better and he was now able to bend and stretch his left leg which he demonstrated. Resident #60 stated he had not been able to move his left hip and leg like that previously due to pain. Review of the facility's Pain Management and Assessment policy (implementation date not recorded) indicated the use of a one to ten pain scale revealed a ten severity represented it being the worst pain a resident had ever experienced. This deficiency represents non-compliance investigated under Complaint Number OH00159033.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 22653 Based on medical record review, review of controlled drug administration records and interview, the facility failed to ensure accuracy of records regarding medication administration. This affected one (Resident #60) of six residents reviewed for pain. Findings include: Review of Resident #60's medical record revealed diagnoses including osteoarthritis of the hips and osteonecrosis of the left femur. On 11/01/24, an order was written for ultram (pain medication) 50 milligrams (mg) to be administered every eight hours as necessary for pain. Comparison of the November Medication Administration Record (MAR) and the controlled drug administration record revealed discrepancies described below. The MAR indicated ultram was administered on 11/05/24 at 9:34 A.M. There was no documentation of the withdraw of the ultram for that date and time. The MAR indicated ultram was administered on 11/06/24 at 8:37 P.M. The controlled drug administration record indicated ultram was removed at 10:00 (what appeared to be 10 A.M.). The MAR indicated Resident #60 received ultram on 11/07/24 twice (at 10:51 A.M. and 9:38 P.M.) The controlled drug administration record indicated the withdraw of three doses of ultram that day (the times of one of the doses were difficult to read with the first dose signed out appearing to say 2051 (military time for 8:51 P.M.) but was recorded before doses were signed out at 11:30 A.M. and 9:40 P.M. The MAR indicated ultram was administered on 11/08/24 at 8:01 A.M. and 9:00 P.M. The controlled drug administration record indicated the withdraw of ultram at 5:32 (no indication of A.M. or P.M.), 8:00 A.M. and 9:00 P.M. On 11/10/24 at 9:00 P.M., ultram was withdrawn from the card of medications. There was no documentation on the MAR as to its administration. On 11/13/24 at either 8:00 P.M. or 10:00 P.M. a dose of ultram was removed with no documentation as to it being wasted or administered. On 11/14/24 at 3:20 P.M., the Director of Nursing (DON) verified discrepancies between Resident #60's MAR and controlled drug administration record. On 11/14/24 at 3:50 P.M. Licensed Practical Nurse (LPN) #200 stated she knew the ultram withdrawn on 11/13/24 was wasted as the night shift nurse waited until she arrived and they disposed of it together but she forgot to sign the form.