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	07/02/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility self-reported incident (SRI) review, interview and facility policy review, the facility failed to ensure Resident #61 was free from misappropriation. This affected one (Resident #61) of one resident reviewed for abuse, neglect and misappropriation and had the potential to affect all residents residing in the facility. The facility census was 102.Findings include:Review of the medical record for Resident #61 revealed an admission date of 02/13/25 with diagnoses including type two diabetes mellitus with hyperglycemia, acquired absence of right leg below the knee, encounter for orthopedic aftercare following surgical amputation, chronic obstructive pulmonary disease (COPD), need for assistance with personal care, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15. Indicating Resident #61 was cognitively intact. Review of the facility SRI tracking number 261140 dated 06/02/25 revealed Resident #61 reported to the facility that 400 dollars was missing from her purse. Review of the investigation into SRI tracking number 261140 revealed Resident #61 counted her money on 06/02/25 at 2:30 A.M. There was 736 dollars in her purse. Resident #61 stated she never left the room until around 9:50 A.M. to go to the shower room. Resident #61 stated she returned to her room around 10:20 A.M. Later that day, Resident #61 checked her purse and there was only 336 dollars in it. Resident #61 then reported it to her nurse who in turn notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA and DON reviewed the contents of the purse which contained 336 dollars. A review of video footage within the investigation revealed the only person that entered the room of Resident #61 while she was in the shower was Certified Nurse Aide (CNA) #323. The police were notified.Review of a witness statement by the LNHA dated 06/04/25 revealed a review of video footage. CNA #323 was seated at the nurse's station at 10:05 A.M. on 06/02/25. CNA #323 was then seen looking around, appearing to assess her surroundings, including observing what the nurse at the station was doing. CNA #323 proceeded to walk toward the room of Resident #61 peered inside, then turned and walked down the hallway seemingly to confirm that Resident #61 and staff were still in the shower room. At 10:07 A.M, CNA #323 quickly returned to the room of Resident #61 and entered. CNA #323 did not leave the room until 10:09 A.M. Also, within the witness statement and review of the video footage, it was noted that CNA #323 was the only person to enter the room of Resident #61 during the noted time frame. Review of a statement by the LNHA dated 06/06/25 within the investigation revealed he had contacted [NAME] Police Detective (BPD) #317. BPD #317 stated, based on review of video footage showing CNA #323 entering the room for an extended period, her body language, and her inquiries regarding the status of surveillance cameras, the prosecutor has determined there was sufficient circumstantial evidence to proceed with the case.Review of a court document ticket #25B009852 dated 06/10/25 revealed a warrant to arrest CNA #323 was issued for theft less than 1000 dollars. Review of a time punch for CNA #323 revealed the last day worked was 06/02/25. CNA #323 punched out at 3:00 P.M.Review of the document titled; Employee Investigation Packet that had the name of CNA #323 on it revealed CNA #323 was suspended on 06/02/25. The document further revealed CNA #323 was terminated on 06/17/25 for theft of resident property. Review of an undated document titled; Employee Corrective Action Form revealed CNA #323 was terminated. The reason was listed as Other: Theft.On 06/26/25 at 10:34 A.M. an interview with BPD #317 revealed based on video footage and witness statements reviewed there was enough evidence to prosecute CNA #323. BPD #317 stated a warrant was issued for a misdemeanor first degree theft against CNA #323.On 06/26/25 at 11:00 A.M. an interview with the LNHA verified the contents of the investigation regarding SRI tracking number 261140. The LNHA stated a warrant was issued for the arrest of CNA #323. The LNHA further stated CNA #323 was suspended pending investigation into the event effective 06/02/25 and terminated from employment 06/17/25. On 06/26/25 at 11:05 A.M. an interview with Resident #61 revealed she had been talked to by LNHA and [NAME] police regarding missing money. Resident #61 stated she always keeps her purse with her but on that day, it slipped her mind. Resident #61 stated she counted her money that morning before her shower and had over 700 dollars. Resident #61 stated when she counted her money later that day, she was missing 400 dollars. Resident #61 stated she then reported it. On 06/26/25 at 12:07 P.M. an interview with CNA #290 revealed she was the aide who showered Resident #61 on 06/02/25. CNA #290 stated Resident #61 was incontinent prior to going to shower room so she changed her and remade the bed. CNA #290 further stated she was accompanied by Physical Therapy Assistant (PTA) #243 as therapy was

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure Resident #106 was safely discharged to another skilled nursing facility. This affected one (Resident #106) of the five residents reviewed for discharge. The facility census was 102. Findings include:Review of the closed medical record revealed Resident #106 was admitted to the facility 05/03/24 with diagnoses of sequelae of cerebral infarction, epilepsy, systemic lupus erythema and autoimmune hepatitis. Resident #106 was cognitively intact and required maximal assistance with toileting hygiene, showers, and dressing along with moderate assistance with personal hygiene and transfers. Review of the progress note dated 03/20/25 at 2:34 P.M. revealed Resident #106 requested to have a referral sent to facilities closer to Akron, Ohio. [NAME] Care in [NAME], Ohio reached out and accepted the referral. All pertinent information requested was sent over for review and the facility accepted. All resident items were packed up by staff. Review of the progress note dated 03/21/25 at 10:08 P.M. revealed Resident #106 had not been transported to the new facility as of yet and all her belongings were gone, and Resident #106 was upset. A call was made to [NAME] Care to check if they had arranged transportation and was informed it was arranged by Greenbriar. Multiple calls were made to local transport companies and transportation was arranged with Emergency Medical Services (EMS) Transport for 03/22/25 with pick-up time between 1:30 P.M. and 3:30 P.M. A call was placed to [NAME] Care to notify them of the date and time of transport. Review of progress note dated 03/22/25 at 10:47 A.M. revealed Social Services confirmed with Admissions Director #239 that transportation had been set up and notified Resident #106. Interview on 06/23/25 at 11:38 A.M. with Social Service Designee (SSD) #211 revealed Resident #106 requested to discharge to a facility closer to where she originally lived which was in Akron, Ohio. On 03/20/25 SSD #211 received a call from [NAME] Care in [NAME], Ohio reporting they set up transportation and would pick up Resident #106 at 2:15 P.M. At 2:07 P.M. SSD #211 was notified there was a pending authorization. At 2:25 P.M. SSD #211 asked if transportation was still coming. After no response was received, SSD #211 sent a follow-up email at 3:29 P.M. to [NAME] Care admission Director #320. At 3:42 P.M. SSD #211 received an email response that said pending. SSD #211 asked if transportation would be pushed back to the following day and on 03/21/25 at 1:19 P.M., [NAME] Care admission Director #320 replied that the authorization was still pending, and transportation was on standby. At 3:25 P.M. SSD #211 asked again if authorization had been received and at 3:27 P.M. [NAME] Care admission Director #320 replied, no. At 3:29 P.M. SSD #211 emailed [NAME] Care admission Director #320 and provided her personal phone number and requested she be contacted if an authorization was received over the weekend. On 03/22/25 Resident #106 complained about not having left yet and Greenbriar Admissions Director #239 contacted [NAME] Care to find out what the holdup was and one of [NAME] Care's nurses read Greenbriar Admissions Director #239 a progress note that stated they were waiting for Greenbriar to set up transportation. Afterwards, Greenbriar admission Director #239 called and set up transportation. On 03/22 at 9:04 A.M. [NAME] Care admission Director #320 emailed SSD #211 at 9:04 A.M. to notify her authorization was still pending. SSD #211reported she did not have remote access to her email so the email from [NAME] Care admission Director #320 was not received until 03/24/25. On 03/24/25 at 3:24 P.M. SSD #211 replied to [NAME] Care admission Director #320 that she was unaware there was no authorization and reported a nurse at [NAME] Care read [NAME] Briar admission Director a progress note that [NAME] was waiting for Greenbriar to arrange transportation. SSD #211 explained she found out a week later that Resident #106 was not admitted to [NAME] Care and was diverted to a hospital where she remained in the emergency department for approximately one week. SSD #211 reported she later found out that [NAME] Care was out of network for Resident #106 and because of that they needed five denials before they could accept her. The Administrator spoke with Resident #106 and offered to allow her to return to Greenbriar, which she declined. SSD #211 stated it was a bad discharge.Review of the email conversation between SSD #211 and [NAME] Care admission Director #320 on 03/20/25 revealed the following: At 2:07 P.M. [NAME] Care admission Director #320 notified SSD #211 that there was a pending authorization from her Managed Care Organization (MCO) which was United Healthcare. At 2:25 P.M. SSD #211 asked if transportation was still coming. At 3:29 P.M. SSD #211 sent a follow-up email asking for an update. At 3:42 P.M. [NAME] Care admission Director #320 responded pending. At 4:08 P.M. SSD #211 asked if transportation would be pushed back to 03/21/25. At 4:15 P.M. [NAME] Care admission Director #320 responded unfortunately

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, observation and facility policy review, the facility failed to ensure sufficient staff to meet the needs of the residents. This affected four (Residents #83, #49, #42, and #95) interviewed regarding staffing concerns and had the potential to affect all 102 residents residing in the facility. Findings include:Interview on 06/23/25 at 9:33 A.M. with Resident #83 revealed there was only one nurse, and one aide scheduled daily.Interview on 06/23/25 at 9:56 A.M. with Resident #49 revealed the unit was understaffed, and the call light response was poor. Interview on 06/23/25 at 10:28 A.M. with Resident #42 revealed the Certified Nursing Assistants (CNAs) were lazy and would stand in the hallway talking while call lights were sounding which resulted in lengthy call light responses. Interview on 06/23/25 at 10:45 A.M. with Resident #90 revealed there was never enough staff and usually only one nurse and one aide working. Interview on 06/24/25 at 2:25 P.M. with Resident #95 revealed there was a day when there was one aide for 45 residents. Interview on 06/23/25 at 1:36 P.M. with CNA #253 she was scheduled on the Providence unit from 7:00 A.M. to 3:00 P.M. but was moved to the Lifestyle II unit due to there were no CNAs there that morning, which was likely due to call offs or staff running late. CNA #253 reported that inadequate staffing interfered with residents receiving proper care.Interview on 06/23/25 at 2:10 P.M. with CNA #311 revealed staffing levels were always short, CNA's felt overworked at times, and care, such as showers, were not always provided as a result. Interview on 06/23/25 at 10:59 A.M. with Staff Scheduler #211 revealed staffing levels were based on facility census and then staffed by each hallway. For Lifestyle II unit the census was 26. Staff Scheduler #211 reported that the facility was overstaffed.Interview on 06/23/25 at 10:25 A.M. with Licensed Practical Nurse (LPN) #214 revealed there was not enough staff. LPN #214 stated there was only one aide on her unit from 7:00 A.M. until 10:00 A.M. LPN #214 stated she called her supervisor and the scheduler and received no help until 10:00 A.M. LPN #214 was tearful during the interview and stated the residents deserved better. LPN #214 stated this is a frequent occurrence. Interview on 06/24/25 at 11:10 A.M. with LPN #208 revealed she was behind with her medication pass, which was related to not having enough staff. LPN #208 stated there were only two aides on the 100-unit that day and she had to assist with patient care. Interview on 06/25/25 at 10:15 A.M. with CNA #290 revealed staffing was an issue in the facility. CNA #290 reported the 200-unit operated best with four aides, but there were only three that day. CNA #290 reported she barely got her work completed as a result. While incontinence care was always completed, sometimes showers must wait until the next day. CNA #290 also reported Administration was not responsive to resident care needs based on census.Interview on 06/25/25 at 10:35 AM interview with LPN #208 revealed she worked the afternoon shift from 3:00 P.M. to 11:00 P.M. the previous evening with only two CNAs most of shift and made repeated attempts to contact the scheduler. On 06/25/25 at 10:40 A.M. an interview with CNA #212 revealed they often work short staffed due to report offs and tardiness. CNA #212 stated it took hours to get help in and reported most nurses do not help with get ups and call lights. Interview on 06/25/25 at 10:55 A.M. with CNA #211 who was also the scheduler verified there were two aides on the 200-unit on 06/24/25 for 1.5 hours at the beginning of the shift. CNA #211 stated there were three aides on 200-unit from 4:30 P.M. to 5:30 P.M. then two aides again until 7:00 P.M. CNA #211 stated there were three aides for the remainder of the shift. On 06/26/25 at 12:30 P.M. an interview with Physical Therapy Assistant (PTA) #243 revealed staffing was an issue and reported she assisted with answering call lights and had brought staffing issues to the Administrator and Director of Nursing (DON); however, the issues were not addressed. On 06/26/25 at 12:55 P.M. an interview with Occupational Therapist (OT) #321 revealed there was an issue with staff showing up on time; however, staffing issues were addressed in management meetings. Observation on 06/26/25 at 7:19 A.M. revealed only one nurse was present on the Lifestyle II unit. Interview at the time of the observation with LPN #293 confirmed she was the only one on the unit and that no CNAs arrived at 7:00 A.M. as scheduled. LPN #293 did not have a schedule and was unsure which staff were scheduled.Observation on 06/26/25 between 7:19 A.M. and 7:30 A.M. Activity Director #257 and Registered Nurse (RN) #233 were observed asking LPN #293 if there were any CNAs on the unit to which LPN #293 responded, no. Interview on 06/26/25 at 9:32 A.M. with LPN #293 revealed multiple complaints related to inadequate staffing on the Lifestyle II unit were made to Unit Manager #314 and the DON in writing but unattendance and tardiness continued. LPN #293 kept copies of the written staffing complaints and provided them. LPN #293 also confirmed the night shift left promptly at 7:00 A.M., and no one stayed over to

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and contract review, the facility failed to ensure medications were administered as ordered in a timely fashion after admission for Resident #111. This affected one (Resident #111) of eight residents who were reviewed for medication administration. The facility census was 102. Findings include:Review of the medical record for Resident #111 revealed an admission date of 06/29/25 at 6:50 P.M. with diagnoses including vesicointestinal fistula, peritoneal abscess, encounter for surgical aftercare following surgery on the digestive system, acute diastolic heart failure, hypothyroidism, arteriosclerotic heart disease, hypertension, and gastroesophageal reflux. Review of the admission assessment dated [DATE] revealed Resident #11 was alert and oriented.Review of the care plan dated 06/29/25 revealed Resident #111 had an infection. Interventions included administering antibiotics per medical providers orders. The care plan also revealed Resident #111 utilizes antidepressant medication. Interventions included administering medications as ordered.Review of the physician's orders included assessing Resident #111's pain level every shift. With each new medication order, the medication may be held until it arrives from the pharmacy, fluoxetine (an antidepressant) 40 milligrams, give two capsules by mouth in the morning for depression, amoxicillin (an antibiotic) 875 milligrams give one tablet by mouth every 12 hours four bacterial infection for five days dated 06/29/25, omeprazole (a medication that reduces stomach acid) 40 milligrams one capsule by mouth in the morning for reflux, metoprolol (a blood pressure medication) 25 milligrams one tablet by mouth daily for hypertension, loratadine (an antihistamine) 10 milligrams one tablet daily for allergies, isosorbide (a medication for coronary artery disease) extended release tablet 60 milligrams one tablet by mouth in the morning for coronary artery disease, levothyroxine (a medication for thyroid gland function) 100 micrograms give one and a half tablets daily for hypothyroidism, diazepam (an antianxiety medication) two milligrams give one tablet by mouth every eight hours as needed for anxiety dated 06/30/25, and oxycodone (a narcotic pain medication) five milligrams give one tablet by mouth every six hours as needed for seven days dated 06/30/25. Review of the medication administration record (MAR) dated 06/01/25-06/30/25 revealed fluoxetine 40 milligrams with a start date of 06/30/25 at 7:00 A.M. was not administered as ordered, isosorbide 60 milligrams with a start date of 06/30/25 at 5:00 A.M. was not administered as ordered, levothyroxine 100 micrograms with a start date 06/30/25 at 5:00 A.M. was not administered, metoprolol 25 milligrams with a start date of 06/30/25 at 7:00 A.M. was not administered, omeprazole 40 milligrams with a start date of 06/30/25 at 5:00 A.M. was not administered and amoxicillin 875 milligrams with a start date of 06/29/25 at 9:00 P.M. was not administered. Review of the facility stock medication list revealed the following medications were available in the facility starter kit (a house stock of medications to be utilized until medications can be delivered from the pharmacy): isosorbide, levothyroxine, metoprolol, omeprazole, and amoxicillin and could have been administered. On 07/02/25 at 8:48 A.M. an interview with Registered Nurses (RNs) #258 and #314 revealed there was an issue starting 06/27/25 with the facility computer system communicating with the pharmacy system regarding new medications. On 07/02/25 at 10:00 A.M. an interview with Resident #111 revealed she did not start getting medications until the evening of 07/01/25. On 07/02/25 at 1:00 P.M. an interview with Corporate Compliance RN #325 verified the house stock medication list, and the medications that could have been started for Resident #111.A review of a document titled; Pharmacy Services Agreement, signed on 05/01/25, revealed the pharmacy will deliver to the facility any prescriptions and supplies at least daily Monday through Sunday. Exhibit A of the document revealed the pharmacy will supply medications to the facility and its residents in a prompt and timely manner, provide house stock of medications to the facility, provide 24 hour seven days a week emergency pharmaceutical services via an on-call pharmacist and provide the facility with a medication administration system. This deficiency represents non-compliance investigated under Master Complaint Number OH00167150 (1272221) and Complaint Numbers OH00166373 (1272215), Complaint Numbers OH00163755 (1272216), and OH00164858 (1272218).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to store insulin (a medication used to stabilize blood sugars) in a proper manner to ensure efficacy. This affected six (Residents #27, #61, #76, #90, #99, and #109) of 23 (Residents #3, #12, #27, #30, #31, #35, #40, #41, #49, #50, #52, #55, #61, #73, #75, #76, #78, #87, #90, #94, #95, #99, and #109) who were identified as utilizing insulin. The facility census was 102.Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of 02/10/23 with diagnosis including type two diabetes mellitus with diabetic chronic kidney disease, and long-term use of insulin. Significant orders included Fiasp FlexTouch (a fast-acting insulin)100 units per milliliter solution pen-injector: Inject five units subcutaneously before meals for diabetes mellitus. hold for blood sugar less than 130, dated 3/5/25. Review of the quarterly Minimum Data Set Assessment (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating Resident #27 was cognitively intact. Review of the care plan dated 06/02/25 revealed Resident #27 had diabetes. Interventions included administering insulin injections per order. On 06/23/25 at 10:25 A. M. an observation of the medication cart for the 400 unit revealed an aspart insulin pen (generic brand of Fiasp) for Resident #27 that was opened and undated. Licensed Practical Nurse (LPN) # 214 verified the aspart insulin pen for Resident #27 was opened and not dated at the time of the observation. 2. Review of the medical record for Resident #90 revealed an admission date of 02/11/23 with diagnosis including type two diabetes mellitus with hyperglycemia, and long-term use of insulin. Significant orders included Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 Unit/Milliliter (Insulin Lispro) Inject as per sliding scale: if blood sugar is 0 - 150 = 0 units Give 6 units with meals plus mod dose 2 units for every 50 above 150; 151 - 200 = 2 units; 201 - 250 = 4units; 251 - 300 = 6units. If blood sugar is greater than 300 give 8 units, subcutaneously with meals, dated 04/15/25. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS of 15 oout of 15, indicating Resident #90 was cognitively intact.Review of the care plan dated 04/25/25 revealed Resident #90 had diabetes. Interventions included administering insulin injections per order. On 06/23/25 at 10:25 A.M. an observation of the medication cart for the 400 unit revealed a Humalog insulin pen (name brand for lispro) for Resident #90 that was opened and undated. LPN # 214 verified the Humalog insulin pen for Resident #90 was opened and not dated at the time of the observation. 3. Review of the medical record for Resident #99 revealed an admission date of 10/07/20 with diagnosis including type two diabetes mellitus with diabetic polyneuropathy. Significant orders included Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 Unit/Milliliter, Inject eight units subcutaneously before meals for diabetes mellitus. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS of 15 out of 15, indicating Resident #99 was cognitively intact. Review of the care plan dated 04/16/25 revealed Resident #99 had diabetes. Interventions included administering medications per medical provider ordersOn 06/23/25 at 10:25 A.M. an observation of the medication cart for the 400 unit revealed a Fiasp insulin pen for Resident #99 that was opened and undated. LPN # 214 verified the Fiasp insulin pen for Resident #99 was opened and not dated at the time of the observation. 4. Review of the medical records for Resident #61 revealed an admission date of 02/13/25 with diagnoses including type two diabetes mellitus with hyperglycemia. Significant orders included Insulin Lispro Injection Solution 100 Unit/Milliliter, inject as per sliding scale: if blood sugar is 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 399 = 8 units; 400 - 600 = 8 units and call medical doctor for further orders, dated 06/20/25.Review of the quarterly MDS assessment dated [DATE] revealed a BIMS of 15 out of 15, indicating Resident #61 was cognitively intact. Review of the care plan dated 05/15/25 revealed Resident #61 had diabetes. Interventions included administering medication per medical providers orders.On 06/23/25 at 11:00 A.M. an observation of the medication cart on the 200-hall revealed lispro insulin pen for Resident #61 opened and not dated. Registered Nurse (RN) #314 verified the lispro insulin pen for Resident #61 was opened and not dated at the time of the observation. 5. Review of the medical record for Resident #76 revealed an admission date of 01/10/25 with diagnoses including type two diabetes mellitus with diabetic polyneuropathy. Significant orders included glargine insulin subcutaneous solution pen injector 100 Units/Milliliter, inject 25 units subcutaneously two times a day for diabetes, dated 01/10/25.Review of the significant change MDS assessment dated [DATE] revealed a BIMS of 15 out of 15, indicating Resident #76 was cognitively intact. Review of the care plan dated 06/13/25 revealed Resident #76 had diabetes with neuropathy. Interventions