

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 02/25/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, interviews, record review, review of the facility incident investigation, and policy review, the facility failed to maintain a hazard free environment free from unsecured smoking materials and smoking inside the facility in undesignated smoking areas. Actual harm occurred on 02/12/26 when Resident #4, who was cognitively intact, wheelchair dependent, and dependent on staff assistance for transfers due to impairment to his lower extremities, lit a cigarette while in his bed and the cigarette fell to contact a flammable agent (cologne) on his bed and on his body. Resident #4 was sent to the hospital on [DATE] for evaluation where he was diagnosed with second degree burns (partial thickness burn that damages the outer layer and underlying layer of skin characterized by severe pain, intense redness, blistering and swelling) to his right thigh. This affected one (Resident #4) of three residents reviewed for smoking. The facility identified 22 residents who smoke. The facility census was 97. Findings include: Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including paraplegia, chronic obstructive pulmonary disease (lung disease), nicotine dependence, bipolar disorder, and chronic pain. Review of the smoking assessment for Resident #4 dated 11/20/25 completed by Licensed Practical Nurse (LPN) #203 revealed Resident #4 was independent with smoking. Review of facility documents titled Smoking Acknowledgement Form and Resident Smoking Guidelines, signed by Resident #4 and dated 11/20/25 acknowledged receipt of the smoking policy and the resident smoking guidelines. The smoking guidelines indicated smoking materials were to be kept by facility staff, smoking was to occur only in designated areas and smoking materials were to be returned to facility staff when done smoking. This was for all smokers. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact, had impairment on both sides of the lower extremities, used a wheelchair for mobility, required set-up assistance for eating, was dependent on staff for transferring, and had adequate vision, sight, and hearing. Review of the care plan dated 01/14/26 documented Resident #4 was a smoker. The goal was to utilize nicotine products in a safe manner. Interventions included smoking evaluation, educating the resident on designated smoking areas, educating on the facility smoking policy, and providing safe smoking devices if required. Review of a facility incident investigation dated 02/12/26 revealed on 02/12/26 at approximately 02:50 A.M. Certified Nurse Aide (CNA) #612 authored a witness statement documenting Resident #4 activated his call light. When staff entered the room they noticed a haze, a chemical smell, and noticed burns on Resident #4's clothes. The nurse was immediately notified that help was needed. CNA #612 noted a cologne bottle was on the floor. Review of the staff witness statement dated 02/12/26 at approximately 02:50 A.M. authored by Licensed Practical Nurse (LPN) #562 revealed that when she arrived to the room, she noticed a [NAME] of smoke, a chemical odor, and Resident #4 had burn marks on his clothes. Emergency Medical Services (EMS) was</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365853	Facility ID: 365853 If continuation sheet Page 1 of 4

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