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	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Center	8064 South Avenue Boardman, OH 44512

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on record review and interview the facility failed to ensure Resident #101's Power of Attorney (POA) signed Resident #101's admission paperwork as the resident's representative. This affected one resident (Resident #101) out of three residents reviewed for admissions. The facility census was 95. Findings include: Review of Resident #101's closed medical record revealed an admitted [DATE] with diagnoses including aphasia, following cerebral infarction, Parkinson's disease, type two diabetes mellitus, chronic kidney disease, muscle wasting and atrophy. Review of POA documents dated 05/29/25 revealed Resident #101's wife was designated POA. Review of Resident #101's admission paperwork revealed all admission paperwork was signed by Resident #101's son-in-law on 02/07/25 who was not an authorized representative of Resident #101 or his POA. Review of Resident #101's discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. required supervision or touching assistance for eating, substantial to maximal assistance with dressing and bed mobility. Resident #101 was dependent on staff for oral hygiene, toileting hygiene, showers, and personal hygiene. Interview on 03/10/25 at 2:57 P.M. with Resident #101's family member revealed the POA was not given an opportunity to review and sign Resident #101's admission documents and instead the admissions girl came to Resident #101's room with an ipad stating she needed a family signature to finish some paperwork and had Resident #101's son-in-law sign and the son-in-law was not the POA. Interview on 03/11/25 at 3:30 P.M. with the Admission Director (AD) #842 verified Resident #101's son-in-law who was not his POA signed all admission paperwork including the Admission Agreement, Guarantor Agreement, Assignment of Benefits, Electronic Medical Record (EMR) photo consent, Vendor Consultation Consent for Ancillary Services or Insurance Plan Enrollment, Admission Checklist, Responsible Party/Resident Representative Agreement, Medicare Secondary Payer Determination, Authorization to Share Medical Information, Receipt of Information, and the Pharmacist Consult Agreement for Drug Therapy Management with Physician Patient Authorization and Consent for Care paperwork. AD #842 verified the POA should have signed as the POA for Resident #101. This deficiency represents non-compliance identified during investigation of Complaint Number OH00162996.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation, interview, record review and review of facility policy, the facility failed to ensure a call light was within reach for Resident #52. The facility also failed to ensure Resident #3 and #28 were reasonably accommodated by staff in response to call light activation for care needs. This affected three residents (Resident #3, #28 and #52) of 31 residents reviewed for call lights. The facility census was 95. Findings include: 1. A review of medical records for Resident #52 revealed a date of admission [DATE]. Significant diagnoses included unspecified head injury, unspecified dementia and cognitive communication deficit. Significant orders included up ad lib with wheeled walker, scheduled toileting to promote continence, and hospice care. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #52 had moderate cognitive impairment. The MDS also revealed Resident #52 had hearing aids, had clear speech and could make self understood. Resident #52 was occasionally incontinent of bowel and bladder. Review of the care plan dated [DATE] revealed Resident #52 had an activity of daily living (ADL) self-care performance deficit. Partial to moderate assistance for toileting (helper does less than half the effort), place call light within reach and remind resident to call for assistance. On [DATE] at 11:00 A.M. an observation revealed Resident #52 was sleeping in bed. The call light activation button was observed on the floor and behind the nightstand. Corporate Registered Nurse (CRN) #932 verified the location of the call light activation button at the time of the observation. 2. A review of medical records for Resident #3 revealed a date of admission of [DATE]. Significant diagnoses included chronic obstructive pulmonary disease and diabetes mellitus type two. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also revealed Resident #3 had no communication issues and was frequently incontinent of bowel and bladder. A care plan dated [DATE] revealed Resident #3 had an activity of daily living (ADL) self-care performance deficit. The care plan also revealed Resident #3 was non-ambulatory and assistance with ADLs may fluctuate. Interventions included to place call light within reach and remind resident to call for assistance. Review of the facility documents titled Resident Council Minutes, dated [DATE] and [DATE] revealed multiple facility staff were in attendance at the meetings. An order of old business was documented to reflect staff were educated on the call lights at night and the staff would continue to be educated on timely answering of the call lights. Also, residents voiced concerns the aides sat at the desk and did not assist them with their needs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the concern logs dated [DATE] and February 2025 revealed concerns for call lights. The Ombudsman was listed as identifying concern with call lights. On [DATE] at 10:00 A.M. an interview with the Ombudsman revealed the Ombudsman had current concerns related to facility staff not answering resident call lights in a reasonable amount of time. On [DATE] at 11:53 A.M. an interview with Resident #3, who regularly attended the resident council meetings, revealed she had expressed concern at the meetings that call lights were not answered timely and the facility administration was aware of this issue. 3. A review of medical records for Resident #28 revealed a date of admission of [DATE]. Significant diagnoses included cerebral infarction, hemiplegia (weakness on one side of the body) to the nondominant left side. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 (cognitively intact). The MDS also revealed no communication deficits and Resident #28 was frequently incontinent of bowel and bladder. Review of the care plan dated [DATE] revealed Resident #28 had an ADL self-care performance deficit. Interventions included total dependence for toileting (helper does all the effort), mechanical lift required with transfers with two staff assist and place call light within reach and remind resident to call for assistance. On [DATE] at 10:15 A.M an observation of call lights for Resident #28 revealed the call light was activated by Resident #28 at 10:15 A.M. and as of 10:30 A.M. there was no staff observed entering the resident's room to answer the resident's call light. On [DATE] at 10:40 A.M. an interview with Resident #28 revealed her call light had been on for approximately 15 minutes and no staff had entered the room to help her since she had activated her call light. Resident #28 stated the staff do not answer call lights timely with her longest wait time being up to 45 minutes. A review of the policy titled Resident Rights, undated, revealed residents will have a method to communicate needs to staff. A call light or bell access will be within reach of the resident as one method to communicate needs to staff. Staff will answer call needs promptly. Any staff within the vicinity will answer call light and notify the appropriate personnel for care needs that may not be immediately remedied including but not limited to toileting, medications, and medical care.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on record review and interview the facility failed to ensure a bed hold letter was mailed to Resident #101's Power of Attorney (POA). This affected one resident (Resident #101) of three residents reviewed for notification of bed hold. The facility census was 95. Findings include: Review of Resident #101's closed medical record revealed an admitted [DATE] and a discharge date of [DATE]. Resident #101's diagnoses included aphasia, following cerebral infarction, Parkinson's disease, type two diabetes mellitus, chronic kidney disease, muscle wasting and atrophy. Review of Resident #101's POA documents, dated 05/29/2013, revealed Resident #101's wife was designated as POA. Review of Resident #101's discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition, required supervision or touching assistance for eating, substantial to maximal assistance with dressing and bed mobility. Resident #101 was dependent on staff for oral hygiene, toileting hygiene, showers, and personal hygiene. Review of Resident #101's bed hold notice revealed it was never sent via certified mail to the reisdents' POA. Interview on 03/10/25 at 2:57 P.M. with the POA of Resident #101 verified they had not received a notification of bed hold for Resident #101. Interview on 03/11/25 at 3:51 P.M. with the Business Office Manager (BOM) #818 verified Resident #101's bed hold letter was never mailed to the resident's representative/POA. This deficiency represents non-compliance identified during investigation of Complaint Number OH00162996.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on record review and interview, the facility failed to ensure Residents #9, #13, and #56 received the necessary services for showers to maintain personal hygiene. This affected three Residents (#9, #13, and #56) out of seven residents reviewed for showers. The facility census was 95. Findings include: 1. Review of the Grievance/Concern log minutes dated 12/03/24, 01/10/25, 01/22/25, 02/27/25, revealed multiple residents voiced concerns about not receiving showers as scheduled. Review of Resident Council meetings dated 01/29/25 and 02/26/25 revealed residents requested shower aides on shifts to help with showers. Medical record review for Resident #56 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, dysphagia, anxiety, difficulty in walking, cognitive communication deficit. Review of Resident #56's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. She required setup or clean up assistance for eating and was dependent on two staff members for oral hygiene, toileting hygiene, dressing, personal hygiene, bed mobility and showers. Review of Resident #56's care plan dated 02/26/25 revealed the resident had an Activity of Daily Living (ADL) self-care performance deficit requiring assistance with ADL's due to disease process, gait/balance problems, impaired cognition, bowel and bladder incontinence, weakness, right hand contracture, diagnosis of stroke with right hemiplegia, sleep disorder and restless leg syndrome. Interventions included staff assistance with eating, oral hygiene, toileting hygiene, dressing, personal hygiene, and tub/shower assistance by two or more staff members. Review of the facility shower schedule for Resident #56 revealed they were scheduled to have showers completed on every Tuesday and Saturday. Review of Resident #56's shower documentation dated from 02/24/25 to 03/11/25 revealed Resident #56 received seven out of 11 bed baths. Shower documentation indicated on 02/04/25, 03/01/25, 03/08/25 and on 03/11/25 the resident did not receive a shower or bath due to environmental limitations. Interview on 03/17/25 at 11:30 A.M. with the Director of Nursing (DON) and the Corporate Registered Nurse (CRN) revealed they did not know what the Certified Nursing Assistants (CNA) meant when they documented due to environmental limitations and they indicated it should not even be an option. The DON and CRN verified Resident #56 did not receive showers as scheduled. 2. Medical record review for Resident #13 revealed an admitted [DATE]. Diagnoses included epilepsy, paraplegia, chronic obstructive pulmonary disease, obstructive sleep apnea, diabetes mellitus typed two, neuromuscular dysfunction of bladder, and hypertension. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's quarterly MDS assessment dated [DATE] revealed the resident had intact cognition, was independent with eating, required setup or clean up assistance with oral hygiene, substantial to maximal assistance with toileting hygiene and bed mobility and was dependent on staff for showers and personal hygiene. Review of Resident #13's care plan revealed the resident was totally dependent by two staff members for showers or tub transfers with the resident doing none of the effort. Review of Resident #13's shower documentation from 02/05/25 to 03/11/25 revealed the resident received seven bed baths and no showers. Interview on 03/10/25 at 3:30 P.M. with Resident #13 revealed he only received bed baths and was never taken to the shower room. Resident #13 stated the staff have a gurney to use for showers and they do not use it on him. Resident #13 stated he does not feel clean with only getting bed baths and would like to go to the shower room and had expressed this to administration. Interview on 03/17/25 at 11:30 A.M. with the DON and the CRN revealed they confirmed Resident #13 had only received bed baths and not per his schedule or desire to go to the shower room. 3. Medical record review for Resident #9 revealed an admitted [DATE]. Diagnoses included end stage renal disease, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease or end stage renal disease, paraplegia, unspecified, neuromuscular dysfunction of bladder unspecified, type two diabetes mellitus without complications, chronic venous hypertension (idiopathic) with ulcer of left lower extremity, acquired absence of right leg above knee, major depressive disorder, morbid (severe) obesity due to excess calories. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #9 had a lower extremity (hip, knee, ankle, foot) impairment on both sides, mobility device wheelchair dependent, he had a catheter for urination and was occasionally in continent of bowel. He was totally dependent on two staff for transferring and totally dependent on one staff for set up to bathe and he had intact cognition. He was also assessed to be independent in most of his ADLs. He was assessed to be totally dependent on assistance by staff for transferring, personal hygiene, and set up for showers. Resident #9 had intact cognition. Review of Resident #9's plan of care dated 03/06/25 revealed the resident had ADL self-care performance deficit, required assistance with ADLs related to catheter use, incontinence, pain, paraplegia, weakness, end stage renal disease, functional deficit, right above the knee amputation (AKA), diabetes, morbid obesity and non-ambulatory. Interventions include shower/bathe self required substantial maximal assistance, required mechanical lift for transfers, with two-person support. Review of the skin assessment/shower sheets dated 02/01/25 through 03/11/25 revealed Resident #9 only received 8 showers total and failed to receive a shower on 02/04/25, 02/08/25, and 02/18/25. Review of Resident # 9 's shower scheduled revealed Resident # 9 was to receive a shower every Tuesday and Saturday, but his preference was to have showers every other day and only needed assistance with transferring and shower set up and he preferred to shower himself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #9 on 03/10/25 at 4:22 P.M. revealed that some weekends, they get showers and some weekends they aren't even dressed until the afternoon, depending on whose working. Interview with the DON on 03/12/25 at 2:43 P.M. revealed Resident #9 did not allow anyone into the shower with him so staff would get him set-up and he did the rest. The DON confirmed Resident #9 did require maximum assistance with a mechanical lift to transfer for showers, and he did not receive showers as scheduled. Review of the ADL policy, undated, revealed it is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of the facility. Providing routine care by a nursing assistant includes but not limited to the following: assisting or provides for personal care bathing, dressing, toileting, eating, and hydration, and assisting with ambulation, transfer, repositioning, or transport. This deficiency represents non-compliance identified during investigation of Complaint Number OH00162996.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interview and policy review the facility failed to complete pre and post dialysis assessments for Resident #94 on each dialysis treatment day. This affected one resident (Resident #94) of one resident reviewed for dialysis. The facility identified four residents (#9, #76, #86 and #94) as being on dialysis. The facility census was 95. Findings include: A review of medical records for Resident #94 revealed a recent admitted [DATE]. Significant diagnoses included end stage renal disease and dependence on renal dialysis. Significant orders included assess dialysis shunt for thrill (a palpable vibration felt over the dialysis access shunt) or bruit (a sound of blood flowing through the access shunt) every shift, assess dialysis resident upon return from dialysis, no blood pressures/blood draws or intravenous access in left arm due to dialysis shunt, dialysis days Monday, Wednesday and Friday. Review of the five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 was cognitively intact. Active diagnoses within the MDS included dependence on renal dialysis. Special treatments within the MDS revealed Resident #94 to be on dialysis. Review of the care plan dated 02/04/25 revealed Resident #94 was on dialysis therapy. Interventions included on dialysis days administer medications before during or after dialysis according to medical provider orders, communicate with dialysis center regarding medications vital signs, weights, any restrictions, diet orders nutritional and or fluid needs, lab results and who to notify with concerns. Interventions also included evaluate the resident following dialysis treatment and report any abnormal findings to medical provider, the nephrologist, the dialysis center, the resident and or resident representative. A review of resident assessments titled Pre-dialysis assessment dated [DATE] within the medical record revealed only one pre-dialysis assessment was completed since Resident #94's recent admitted [DATE]. A review of resident assessments titled Post-dialysis assessment dated [DATE] within the medical record revealed only one post-dialysis assessment completed since Resident #94's recent admitted [DATE]. On 03/12/25 at 3:45 P.M. an interview with the Assistant Director of Nursing #860 revealed pre and post dialysis assessments are to be done on each dialysis treatment day. On 03/13/25 at 11:00 A.M. an interview with Corporate Registered Nurse (CRN) #934 revealed the only pre and post dialysis assessments completed on Resident #94 were 03/12/25. CRN #934 also verified the facility policy stated to complete pre and post dialysis assessments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/25 at 1:50 P.M. an interview with Medical Secretary #935 from the dialysis center revealed Resident #94 had been at the dialysis center for treatment on 02/03/25, 02/05/25, 02/07/25, 02/10/25, 02/12/25. 02/14/25, 02/17/25, 02/19/25, 02/26/25, 03/03/25, 03/05/25, 03/07/25, 03/10/25 and 03/12/25. A review of the policy titled Hemodialysis Care and Monitoring, undated, revealed in section eight and subtitled, Pre-dialysis: Evaluation is completed within 4 hours of transportation to dialysis include and but not limited to accurate weight, blood pressure, pulse, respirations, in temperature. The evaluation should include medications administered or withheld prior to dialysis. The subsection titled pre dialysis also revealed to send a copy of the nursing evaluation with the resident to the dialysis center including the medication administration record and emergency contacts. In section nine, subtitled, Post Dialysis the nurse is to complete a post dialysis evaluation upon return from dialysis center to include but not limited to checking the thrill of the fistula, checking the bruit of the fistula, checking the pulse in the access limb, checking blood pressure, pulse, respirations, and temperature upon return of the facility, visual inspection of the site for bleeding, swelling and or other abnormalities, and any abnormal or unusual occurrence that the resident reports while at the dialysis center.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on record review, interview and observation the facility failed to ensure medications were administered as ordered by the physician. This affected two residents (Resident #70 and #357) of eight residents reviewed for medication administration. The facility census was 95. Findings include: 1. Review of Resident #357's medical record revealed an admitted [DATE] with diagnoses that included, acute and subacute infective endocarditis, septic arterial embolism, chronic kidney disease, stage two, ST elevation myocardial infarction (STEMI), other psychoactive substance abuse, uncomplicated intravenous drug use with Suboxone, bacteremia, methicillin resistant staphylococcus aureus infection, nicotine dependence. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #357 had intact cognition. Review of Resident #357 care plan dated 03/08/25 revealed a focus of substance use disorder with interventions to administer medications per medical provider's orders and evaluate the resident for the following symptoms (but not limited to) and report to medical provider/resident/ resident representative, if present: stumbling, nodding off even when standing or in mid conversation, incoherent speech/slurred speech, rambling, sleepy erratic behavior, hyperactive, threatening, hostile, blood shot eyes, pin point pupils, pale face, sweaty unruly appearance, fumbling, nervous, jerky movements. Further review of Resident #357's medical record revealed Buprenorphine HCL- Naloxone HCL (Suboxone) Sublingual Film 2-0.5MG, give 2 tablets sublingually every 24 hours was ordered with a start date of 03/08/25. Review of the medication administration record (MAR) revealed this medication was not administered as ordered by the physician on 03/08/25, 03/09/25, and on 03/10/25 it was administered at 10:00 P.M. On 03/13/25 it was not administered as ordered. Review of the pharmacy delivery sheets revealed the Suboxone for Resident #357 was delivered on 03/10/25 and 03/12/25. Interview with Resident # 357 on 03/10/25 at 3:33 P.M. revealed that he did not receive his Suboxone as ordered by the physician. Resident #357 reported the nurse informed him it was not available, and he was concerned. Interview with the Administrator and Corporate Registered Nurse (CRN) #934 on 03/17/25 at 9:21 A.M. verified these medications were not administered on 03/08/25, 03/09/25, and 03/13/25 as ordered by the physician and that the medication did not arrive to the facility until 03/10/25. 2. Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnosis included metabolic encephalopathy, acute respiratory failure,endometrial cancer, venous insufficiency, and chronic stage three kidney disease. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition, required partial to moderate assistance with eating and oral hygiene, substantial to maximal assistance for bed mobility and was dependent for toileting, showers, dressing, and personal hygiene. Review of Resident #70's physician orders dated 03/10/25 revealed they were prescribed Dronabinol capsule 5 milligrams (mg) by mouth one time a day for appetite stimulant. Review of Resident #70's MAR dated 03/10/25 through 03/17/25 revealed Resident #70 had not received the medication as it was not available for administration. Review of Resident #70's progress notes dated from 03/11/25 through 03/17/25 revealed there was no communication with the Physician, Nurse Practitioner, or the Resident's family informing them the Dronabinol 5 mg was not available for administration, nor was there any documentation with the pharmacy regarding the medication not being available. Interview on 03/17/25 at 10:57 A.M. with CRN #934 verified Resident #70's Dronabinol five milligram (mg) dose used for an appetite stimulant due weight loss was ordered on 03/10/25 and had been marked on the MAR as unavailable to be given from 03/11/25 to 03/17/25. CRN #934 also confirmed there was no communication with the physician as to why it was not available nor was there communication with resident's family the medication was not available. Review of the medication administration policy, dated 2013, stated: 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. The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer. Administer medications only as prescribed by the provider. This deficiency represents non-compliance identified during investigation of Complaint Number OH00162996 and OH00161861.

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	03/17/2025

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44810 Based on observations, interviews, and record reviews, the facility failed to ensure Residents #53, #55, and #89 were smoking in a safe smoking area and not an area designated as non-smoking. This affected all three Residents #53, #59, and #89 who were reviewed for smoking. The facility census was 95. Findings include: 1.Review of the medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure with hypoxia, hemiparesis following cerebral infarction, and atrial fibrillation. Review of the entry Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had severe cognitive impairment with a memory problem. Resident #53 required extensive assistance for all activities of daily living. Review of the smoking assessments completed 10/28/24, 01/28/25, and 02/22/25 revealed Resident #53 was an independent smoker. Review of the care plan dated 01/06/25 revealed Resident #53 utilizes nicotine products. Interventions included she will use the products in a safe manner and to educate her on designated smoking areas. 2.Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction, and atrial fibrillation. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #55 had mild cognitive impairment. Resident required moderate assistance with all activities of daily living. Review of the care plan dated 01/26/25 revealed Resident #55 utilizes nicotine products. Interventions included that he will use the products in a safe manner and to educate him on designated smoking areas. Review of the smoking assessments completed 08/23/24, 11/23/24, and 02/24/25 revealed Resident #55 was an independent smoker. Review of the nursing progress note dated 10/17/24 revealed Resident #55 was reeducated on the facility smoking policy and the consequences of violating the policy. Resident #55 verbalized understanding and signed the policy j-off. 3.Review of the medical record for Resident #89 revealed an initial admitted [DATE] and a readmitted [DATE]. Diagnoses included non-pressure chronic ulcer of the right foot, gangrene, hypertension, diabetes mellitus type two, and cannabis use. (continued on next page)

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	03/17/2025

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #89 had intact cognition. Resident #89 required moderate assistance with all activities of daily living. Review of the care plan dated 01/29/25 revealed Resident #89 utilizes nicotine products. Interventions included that he will use the products in a safe manner and staff will educate him on designated smoking areas. Review of the smoking assessment completed 01/15/25 revealed Resident #89 was an independent smoker. Observation on 03/10/25 at 2:20 P.M. revealed Resident #53, #55 with her visitor, and Resident #89 sitting on the back facility patio smoking. The patio was clearly marked with no smoking. All three Residents confirmed that they were smoking in a non-smoking area because they felt the walk to the smoking area was too far. Interview on 03/11/25 at 8:55 A.M. with the Assistant Director of Nursing (ADON) 910 revealed that the facility does not have supervised smoking. All residents are assessed and if they are an independent smoker they can smoke in designated areas when they want to. Interview on 03/13/25 at 2:03 P.M. with Resident #3 reported she had witnessed several residents smoking on the back patio even though they have another patio designated as the smoking area. Resident #3 stated she hoped the facility enforced the smoking policy. Review of the facility policy titled Resident Smoking Guidelines, undated, revealed it is the policy of this facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision. To provide smoke free areas outside on facility grounds for residents who do not smoke and who desire a smoke free area when outside.