

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Greenbriar Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 West Lexington Road Eaton, OH 45320	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure skin care treatments were timely initiated when a resident was admitted with a pressure ulcer. This affected one (#75) of three reviewed for wound care and services. The facility census was 70. Findings include: Medical record for Resident #75 revealed an admission on [DATE] with diagnoses including but not limited to hypertension, type two diabetes mellitus with diabetic neuropathy, peripheral vascular disease, and congestive heart failure. Resident #75 was transferred to the hospital on [DATE] and did not return to the facility. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] for Resident #75 revealed cognitive impairment. Resident #75 required supervision for eating and minimal assistance with bed mobility, transfers and toileting. Resident #75 was coded in section M of the MDS as being at risk for developing pressure ulcers and coded for as having one more unhealed pressure ulcers. Resident #75 was coded with one unstageable deep tissue injury that was present on admission. Resident #75 was not coded with any pressure ulcer care, applications of dressings or topical ointments. Further review of section M revealed it was signed as completed on 08/07/25. Review of the plan of care for Resident #75 dated 08/01/25 was silent for any documentation related to altered skin integrity. Review of hospital discharge orders for Resident #75 dated 07/31/25 was silent for any orders related to impaired skin integrity. Review of the weekly skin assessment for Resident #75 dated 07/31/25 revealed scatter bruising and scabs, buttocks red and skin beginning to peel. Review of the weekly wound assessment for Resident #75 dated 08/01/25 revealed resident had pressure ulcer to sacrum classified as suspected deep tissue injury. Wound measurements documented were 7 centimeters in length, 7.4 cm in width and 0.0 depth. Wound description was documented as resident was admitted from the hospital with this deep tissue injury (DTI) to coccyx, purple in color, top layer of skin peeling and no drainage noted. Wound status was stable, treatment plan documented for zinc-based barrier cream two times a day. Review of the weekly skin assessment for Resident #75 dated 08/05/25 revealed admitted with unstageable to coccyx seen by wound nurse practitioner (NP). Review of the weekly wound assessment for Resident #75 dated 08/11/25 revealed resident had pressure ulcer to sacrum classified as unstageable. Wound measurements documented were 6.5 cm x 4.5 cm x 0. Wound description was documented as resident was admitted from the hospital with this deep tissue injury (DTI) to coccyx, purple in color, top layer of skin peeling and no drainage noted. Wound status was stable, treatment plan documented for cleanse with soap and water, pat dry, apply wound gel and dry dressing daily. Review of the initial wound NP visit for Resident #75 dated 08/11/25 revealed coccyx wound pressure and staged as unstageable. Coccyx wound measures 6.5 cm x 4.5 cm x 0.1 cm. Wound had scant amount of serous drainage. Adherent slough (dead non viable tissue) present on wound was documented as 50 percent of wound area and 50 percent eschar. Treatment plan documented for wound gel and bordered foam dressing everyday and as needed. Recommendations documented included NP was notified by facility on admission of coccyx wound, treatment was initiated upon evaluation today. Will start with wound gel to soften slough and eschar and for chemical debridement. Resident #75 would benefit from low air loss mattress. Review of the weekly skin assessment for Resident #75 dated 08/11/25 revealed resident has previously identified skin areas/abnormalities. Review of the weekly skin assessment for Resident #75 dated 08/18/25 revealed has previously identified skin areas/abnormalities with coccyx pressure noted. Review of the weekly wound assessment for Resident #75 dated 08/18/25 revealed resident had pressure ulcer to sacrum classified as unstageable. Wound measurements documented were 7.0 cm x 4.0 cm x 0. Wound description was documented as resident was admitted from the hospital with DTI, unstageable to coccyx, 100 percent slough with no drainage noted. Wound status was stable, treatment plan documented for cleanse with soap and water, pat dry, apply wound gel and dry dressing daily. Review of the wound NP visit notes for Resident #75 dated 08/18/25 revealed coccyx wound pressure and staged as unstageable. Coccyx wound measures 7.4 cm x 4.0 cm x 0.1 cm. Wound had scant amount of serous drainage. Adherent slough (dead non viable tissue) present on wound was documented as covering 100 percent of wound. Treatment plan documented for wound gel and bordered foam dressing everyday and as needed. Recommendations documented included continue wound gel to help soften slough and promote debridement. Air mattress was ordered per nursing. Review of the weekly wound assessment for Resident #75 dated 08/25/25 revealed resident had pressure ulcer to sacrum classified as unstageable. Wound measurements documented were 7.0 cm x 4.0</p>		