STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365854	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Nursing Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to notify the physician for a change in orthostatic blood pressure and failed to notify a resident's family of new physician orders and changes in condition. This affected one (Resident #58) of twelve residents reviewed for change in condition. The facility census was 66.Findings include:Review of the medical record revealed Resident #68 was admitted to the facility on [DATE] and expired in the facility on [DATE]. Diagnoses included pulmonary fibrosis and congestive heart failure (CHF). The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 had moderately impaired cognition.Review of the physician progress notes dated [DATE] revealed Nurse Practitioner (NP) #190 assessed Resident #68 related to reports of acute cough and congestion, worsening over the last several days. Plan of care included to continue as needed (PRN) medications for cough and new orders for a chest x-ray.Resident #68 had physician orders dated [DATE] for a chest x-ray two view.The physician progress notes dated [DATE] revealed NP #188 assessed Resident #68 as a follow-up to the chest x-ray obtained [DATE] for dyspnea. Abnormal chest x-ray showed interstitial nodular fibrosis. Plan of care included new orders for outpatient chest Computed Tomography (CT) scan with contrast and Prednisone (steroid) 20 milligrams (mg) by mouth daily for five days for cough with follow-up as needed.Resident #68 had physician orders dated [DATE] for CT of the chest, outpatient, related to post chest x-ray results. On [DATE], an order for prednisone oral tablet 20 mg: Give one tablet by mouth one time a day for cough for five days. The physician progress notes dated [DATE] revealed NP #190 assessed Resident #68 regarding complaints of multiple dizzy spells over the last several days, primarily with movement. Physical examination revealed respirations were even and unlabored, and bilateral lungs were clear to auscultation. New orders were placed for orthostatic blood pressure (BP) (to monitor for change in BP that occurs when a person moves from lying down to standing) and a basic metabolic panel.Resident #68 had physician orders dated [DATE] for orthostatic BP for three times daily every shift for monitoring. Review of orthostatic BP readings taken on [DATE] at 6:00 A.M. revealed while lying down, Resident #68's BP measured 126/72, when sitting measured 77/47 (this was a systolic drop of 40 millimeters of mercury (mm Hg) and diastolic drop of 25 mm Hg; this indicates a severe form orthostatic hypotension), and when standing measured 79/53.There was no documentation of Resident #68's family being notified when Resident #68 had a change in condition and new physician orders on [DATE], and when Resident #68 had abnormal chest x-ray results and two new orders including outpatient diagnostic testing and a new medication on [DATE]. There was no documentation of Resident #68's family being notified when Resident #68 had a change in condition on [DATE] and new physician orders. Additionally, there was no documentation of physician notification related to abnormal orthostatic blood pressure readings recorded on [DATE]. During an interview on [DATE] at 2:10 P.M., the Director of Nursing (DON) verified there was no family notification documented in Resident #68's medical record when Resident #68 had changes in condition on [DATE] and [DATE], abnormal x-ray results on [DATE], new physician orders on [DATE] and [DATE]. The DON stated Resident #68 did not want her family to be notified because (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they would insist she go to the hospital, and she did not want to go. The DON verified this was not documented and could not be verified on the medical record. During an interview on [DATE] at 12:45 P.M., NP #190 stated she was not notified of any abnormal blood pressure readings for orthostatic hypotension. She stated she would have expected the nurse to notify the physician if a reading showed a change from 126/62 lying to 77/47 sitting. Review of the policy titled Change in a Resident's Condition dated 08/2023 revealed the facility notified the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition.This deficiency represents non-compliance investigated under Complaint Numbers 2785662 and 2748144.

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to schedule Computed Tomography (CT) testing and obtain results in a timely manner. This affected one (Resident #68) of twelve reviewed for diagnostic services. The facility census was 66.Findings include:Review of the medical record revealed Resident #68 was admitted to the facility on [DATE] and expired in the facility on [DATE]. Diagnoses included pulmonary fibrosis and congestive heart failure (CHF). Review of the care plan dated [DATE] revealed Resident #68 had altered respiratory status and difficulty breathing related to CHF and pulmonary fibrosis. Interventions included obtaining and monitoring labs and diagnostic work as ordered.The physician progress notes dated [DATE] revealed Nurse Practitioner (NP) #188 assessed Resident #68 as a follow-up to the chest x-ray obtained [DATE] for dyspnea. Abnormal chest x-ray showed interstitial nodular fibrosis. Plan of care included new orders for outpatient chest Computed Tomography (CT) scan with contrast.Resident #68 had physician orders for [DATE] for CT of the chest, outpatient, related to post chest x-ray results.There were no results of the CT of the chest in Resident #68's medical record.During a telephone interview on [DATE] at 9:58 A.M., NP #188 confirmed he re-assessed Resident #68 on [DATE] after an abnormal chest x-ray on [DATE] and ordered a CT chest with contrast. NP #188 stated he did not see the CT results and was unaware that the CT had not been performed until [DATE]. If staff notified him the CT was unable to be performed sooner, NP #188 would have re-assessed Resident #68 to determine if she needed more urgent treatment.During an interview on [DATE] at 2:10 P.M., the Director of Nursing (DON) and Regional Registered Nurse (RN) #195 confirmed CT results from CT chest on [DATE] were not available in Resident #68's medical record. Regional RN #195 stated she expected nursing would call to check on results if not received within 48 hours of outpatient testing performed.During an interview on [DATE] at 12:28 P.M., Transporter #162 confirmed he routinely scheduled appointments and transportation with outside providers. Scheduler #162 verified the order for Resident #68's appointment for CT was missed, and he had not called to schedule Resident #68's CT chest until [DATE]. Scheduler #162 stated he only recently learned how to run a new order report in the computer to check for appointments needing to be scheduled. In addition, Scheduler #162 stated he usually provided a fax number for the results to be sent after the test. He did not remember if he had provided a fax number for this test. Review of the policy titled Provision of Physician/Medical Practitioner Services dated [DATE] revealed nurses were to submit timely requests for practitioner-ordered services, including laboratory, radiology, and consultations, to the appropriate entity.This deficiency represents non-compliance investigated under Complaint Number 2748144.