

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 02/27/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967</p> <p>Based on medical record review and staff interview, the facility failed to ensure resident preadmission screening and resident reviews (PASARRs) were accurate and included resident mental health diagnoses and mental health services. This affected three (Residents #02, #61 and #63) of three residents reviewed for PASARRs. The facility census was 71 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #02 revealed an admitted [DATE] with diagnoses including anxiety disorder, major depressive disorder, schizoaffective disorder, type two diabetes mellitus, cerebral infarction, and epilepsy.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #02 dated 01/02/25 revealed the resident was severely cognitively impaired and required assistance with activities of daily living (ADLs.)</p> <p>Review of the PASARR for Resident #02 dated 08/19/24 revealed the resident had mood disorders and panic or other severe anxiety disorders but did not include the resident's diagnosis of schizoaffective disorder.</p> <p>Interview 02/25/24 at 11:18 A.M. with the Administrator confirmed the facility had not listed Resident #02's diagnosis of schizoaffective disorder on the PASARR dated 08/19/24.</p> <p>2. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including psychotic disorder with delusions due to known physiological condition, anxiety disorder, major depressive disorder, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, cerebral atherosclerosis, and type two diabetes mellitus.</p> <p>Review of the MDS assessment for Resident #61 dated 12/14/24 revealed the resident was severely cognitively impaired and was dependent on staff assistance with ADLs.</p> <p>Review of the diagnosis list for Resident #61 revealed the resident had the following psychiatric diagnoses: psychotic disorder with delusions due to known physiological condition, anxiety disorder, and major depressive disorder.</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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the psychiatric progress note for Resident #61 dated 11/18/24 revealed the resident was seen by a mental health provider for neuropsychiatric assessment and management of mood and cognition.</p> <p>Review of the PASARR for Resident #61 dated 01/03/25 revealed there were no mental disorders or psychiatric services listed.</p> <p>Interview on 02/25/24 at 11:23 A.M with the Administrator on confirmed the facility had not listed Resident #61's diagnoses of psychotic disorder with delusions due to known physiological condition, anxiety disorder, and major depressive disorder on the PASARR dated 01/03/25 nor had the facility noted Resident #61's psychiatric services.</p> <p>25908</p> <p>3. Review of the medical record for Resident #63 revealed a admitted [DATE] with diagnoses including Parkinson's disease, and bipolar disorder.</p> <p>Review of the MDS assessment for Resident #63 dated 01/01/25 revealed the resident had severely impaired cognition and required maximum staff assistance with ADLs.</p> <p>Review of the PASARR for Resident #63 dated 01/03/25 revealed it did not include the resident's diagnosis of bipolar disorder.</p> <p>Interview on 02/27/25 at 1:18 P.M. with Social Worker (SW) #31 confirmed the facility did not include Resident #63's diagnosis of bipolar disorder on the PASARR dated 01/03/25.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff properly monitored residents receiving anticoagulants for bruising and bleeding. This affected one (Resident #16) of five residents reviewed for unnecessary medications. The facility census was 71 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including end stage renal disease, chronic obstructive pulmonary disease, and hyperlipidemia.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #16 dated 12/16/24 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), and received anticoagulant medication.</p> <p>Review of the care plan for Resident #16 dated 05/01/24 revealed the resident was on an anticoagulant related to a history of stroke. Interventions included the following: administer medications as ordered, monitor for side effects, include the resident in the treatment plan, monitor vital signs and laboratory values.</p> <p>Review of the physician's orders for Resident #16 revealed an orders dated 12/26/23 for Eliquis 2.5 milligrams (mg) twice daily and to monitor the resident for signs and symptoms of bleeding and report to the physician due to Eliquis administration.</p> <p>Review of the progress note for Resident #16 dated 08/20/24 per Nurse Practitioner (NP) #500 revealed the resident had dry nostrils and had a minor nosebleed. NP #500's plan was for staff to apply petroleum jelly to the resident's nostrils as needed.</p> <p>Review of the progress notes for Resident #16 dated 12/27/24 to 02/24/25 revealed no documentation of bruising and/or bleeding (nosebleeds.)</p> <p>Review of the skin assessment for Resident #16 dated 02/10/25 revealed the resident had scattered scabs on the arms where the resident had picked the skin.</p> <p>Review of the skin assessment for Resident #16 dated 02/17/25 revealed the resident had no new skin areas.</p> <p>Observation on 02/24/25 at 11:04 A.M. revealed Resident #16 had a piece of tissue paper in his right nostril that had a red drop on it. Resident #16 also had large bruises that were approximately two inches long by two inches wide on both hands.</p> <p>Interview on 02/24/25 at 11:14 A.M. with Resident #16 confirmed he had frequent nose bleeds and bruises on both of his hands because he was on an anticoagulant.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/25/25 at 4:30 P.M with the Director of Nursing (DON) confirmed Resident #16 had large bruises on both of his hands and there was no documentation of the bruising or notification to the physician of the bruising in the resident's medical record. The DON confirmed Resident #16 also had frequent nose bleeds and was on an anticoagulant. The DON confirmed the facility had not documented appropriate monitoring of Resident #16 for side effects of Eliquis.</p> <p>Review of the facility policy titled Anticoagulant Medications dated 03/07/23 revealed residents that received anticoagulants should be assessed for adverse reactions such as bruising, bleeding gums, rectal bleeding, bloody urine and changes in mental status. Any adverse reactions should be reported to the attended physician and documented in the medical record.</p>		