STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365853	A. BUILDING _____ B. WING _____	08/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0157 **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 the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #105's physician was notified of an elevated blood sugar and failed to ensure the resident's physician was notified when routine insulin ([MEDICATION NAME] N) was being held. The facility failed to ensure Resident #214's physician was notified of blood sugar results based on the physician ordered parameters for notification. The facility also failed to ensure Resident #89's physician and family were notified timely of the development of two Stage II pressure ulcers. This affected three residents (Resident #105, #214 and #89) of 22 residents whose records were reviewed during the survey. Findings include: 1. On 08/13/14 at 7:43 A.M. Licensed Practical Nurse (LPN) #16 was observed administering medication to Resident #105. Interview with LPN #16 revealed the resident would be leaving the facility to go to [MEDICAL TREATMENT] around 8:00 A.M. on this date. Interview with the LPN and Resident #105 at the time of the medication administration revealed the resident had already eaten her breakfast and was waiting to leave for [MEDICAL TREATMENT] at that time. Prior to preparing the resident's medication, LPN #16 was observed checking Resident #105's blood sugar. The blood sugar was noted to be 129. No insulin was administered at that time. Record review revealed Resident #105 went to [MEDICAL TREATMENT] three times per week, on Monday, Wednesday and Friday. Review of the resident's current physician medication orders and Medication Administration Record [REDACTED]. The order indicated to notify the physician if the blood sugar was less than 70 or greater than 300. The blood sugar checks were scheduled to be completed at 8:00 A.M., 4:30 P.M. and 9:00 P.M. Record review revealed the resident also had a current physician order to administer insulin, [MEDICATION NAME] N 20 units subcutaneously on Monday, Wednesday and Friday. The insulin medication was scheduled to be administered at 8:00 A.M. Record review revealed there were no physician ordered parameters to hold the insulin based on the resident's blood sugar level. The resident also had a physician order for [REDACTED].) on Tuesday, Thursday, Saturday and Sunday (which were non-[MEDICAL TREATMENT] days). A notation completed on the back of the administration record, by LPN #16 revealed the [MEDICATION NAME] N insulin was held on 08/13/14 at 8:00 A.M. because the resident's fasting blood sugar was 129. On 08/07/14 at 8:00 A.M. the resident's blood sugar was noted to be 324. There was no written evidence on the administration record or in the nursing progress notes that the physician was notified of the resident's blood sugar as ordered. On 08/13/14 at 10:05 A.M., interview with LPN #16 revealed Resident #105 had an order for [REDACTED]. on this date. The LPN verified she did not administer the insulin because the resident's blood sugar was 129. The LPN stated it was nursing judgement not to administer the insulin. When asked if the facility had a policy regarding holding insulin per nursing judgement, she stated she wasn't sure. The LPN stated she would normally hold insulin if the resident's blood sugar was under 100. Review of the administration record with the LPN at that time revealed on 08/08/14 at 8:00 A.M. the resident's blood sugar was 76 and her insulin was administered. Continued review of the Medication Administration Record [REDACTED].M. for a blood sugar of 100 and on 08/11/14 at 8:00 A.M. for a blood sugar of 78. Review of the Medication Administration Record [REDACTED]. On 08/13/14 at 11:25 A.M. interview and observation of Resident #105's medical record with the director of nursing (DON) verified the resident did not have physician ordered parameters for holding her 8:00 A.M. dose of insulin on [MEDICAL TREATMENT] days and the facility did not have a policy regarding holding insulin medication per nursing judgement. The DON verified on 08/08/14 a nurse administered the 20 units of insulin as ordered when the resident had a blood sugar of 76 but on 08/06/14 and 08/13/14 it was held for blood sugars of 100 and 129 respectively. The DON also verified the insulin was held at 8:00 A.M. on 08/11/14 for a blood sugar of 78. The DON verified the lack of written nursing progress notes to determine the physician was notified of the insulin medication being held or to obtain parameters for the administration of the medication. On 08/13/14 at 11:55 A.M. interview with the DON revealed a physician clarification order had been obtained, after surveyor intervention that indicated to hold the resident's 8:00 A.M. insulin on [MEDICAL TREATMENT] days if the resident's blood sugar was less than 100. The DON verified the insulin medication should have been administered to Resident #105 on 08/13/14 as the resident did not have any parameters to hold at the time of the administration and then once parameters were obtained, the order was to hold if less than 100. The DON also verified the lack of written evidence to determine the physician was notified on 08/07/14 when the resident's 8:00 A.M. blood sugar was 324. 2. Review of the facility Grievance Quality Assurance (QA) log revealed two entries related to concerns with medication administration involving Resident #214. An entry, dated 06/13/14 generated by the resident's family related to physician notification of blood sugar and on 05/04/14 related to concerns with medications. Both concerns revealed the nurses involved were educated and as a result of the incident on 06/13/14 the nurse was suspended. Review of a nursing progress note, completed by Registered Nurse (RN) #18, dated 06/18/14 at 12:30 P.M. revealed the resident's family told him on 06/13/14 when he did his daily assessment and vital signs around 8:30 A.M. that Resident #214's blood sugar that morning had been 60 and the night nurse (RN #26) told the resident to drink a full glass of cranberry juice. RN #18 documented he had been told in report, by RN #26 that Resident #214's blood sugar had been low but when questioned how low, RN #26 told him the blood sugar was 80. RN #18 indicated the resident's 6:00 A.M. scheduled medications were documented as being administered, however her 6:00 A.M. medications had been placed in a cup and put aside by the window and left with the family to give later. The nursing progress note indicated the resident's family was very upset about this and asked to speak to someone in charge. The nursing progress note indicated the unit manager went to speak with the resident and family. On 08/14/14 at 3:09 P.M. interview with the DON revealed she was aware of an incident related to Resident #214's family voicing a concern related to the resident's blood sugar not being accurately documented and the physician not being notified of a low blood sugar. The DON indicated the incident had occurred on 05/26/14 when the family said they were told by a nurse the resident's A.M. blood sugar was 80 but in fact it was only 66. The DON stated the family was concerned the resident's medical records had been falsified related to her blood sugar levels. The DON then indicated the incident had not occurred on 05/26/14 but on 06/17/14 and the concern was that the family was told one blood sugar result but the nurse documented a different result. During the on-site investigation, a request was made to review the investigation surrounding this incident. The DON provided a form, dated 06/17/14 and titled Teachable Moment. The topic of the form, provided to RN #26, was documentation and indicated when recording blood sugar, blood pressure, any parameters or anything regarding assessment, ensure you are accurate in documentation and recording and follow through with physician orders as prescribed. Document factually assessments and follow through. If you have any doubt of a result obtained, perform the task again for clarification and document. Ensure you report to the oncoming nurse your results. Additional interview with the DON at that time revealed the above teachable moment was in regard to an incident that occurred on 06/13/14. When asked why she wasn't notified until 06/17/14, the DON indicated she didn't know. When asked if there were statements or an investigation completed including statements from the time of the incident from RN #18, RN #26, the resident and/or her family or the unit manager, no additional information was provided. Interview with the DON revealed the

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

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.

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F 0157 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) unit manager at the time of the incident, RN #28, was no longer employed by the facility. Further interview and review of Resident #214's medication administration records and nursing progress notes revealed the resident had frequent changes to insulin orders and blood sugar monitoring parameters. The DON verified the lack of evidence to ensure the resident's blood sugars were always communicated to the resident's physician throughout her stay (from 04/24/14 through 08/02/14) as per the parameters ordered. On 08/14/14 at 7:05 P.M. interview with RN #26, who routinely worked 7:00 P.M. to 7:00 A.M. revealed she had cared for Resident #214 during her stay in the facility. During the interview, RN #26 verified she was the nurse assigned to administer medications to Resident #214 on 06/13/14. The RN stated she recalled checking the resident's blood sugar that morning and it was 60. The RN stated she got the resident a cranberry juice with three sugar packets and had the resident drink it. The RN stated she got called away to another resident and forgot to document the blood sugar and also did not notify the physician (the resident had an order to notify the physician if her blood sugar was less than 80). The RN stated when she was reviewing the Medication Administration Record [REDACTED]. The RN verified the blood sugar of 80 was not accurate and that the resident's blood sugar that morning was actually 60, which required physician notification which she failed to do. 3. Resident #89 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident received Hospice services with a [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) 3.0 assessment of 07/10/14 revealed the resident had severe short and long term memory impairment, required extensive assistance of two persons for bed mobility and transfers, and extensive assistance to meet her needs to toilet, dress, and complete her hygiene needs. Resident #89 was always incontinent of bowel and bladder and was at risk for the development of pressure sores. Review of the progress notes revealed on 08/10/14 at 12:07 A.M., LPN #32 documented an intact fluid filled blister was noted on the resident's right abdomen and three small intact fluid filled blisters were noted on the resident's right hip. There was no evidence the physician or responsible party was notified of the blistered areas. Interview with LPN #19 on 08/14/14 at 9:45 A.M. verified there was no evidence the nurse had notified the physician or responsible party of the blistered areas on Resident #89's abdomen and hip when discovered. This deficiency substantiates Complaint Number OH 668 and Complaint Number OH 945.
F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility missing item communication form the facility failed to promptly attempt to locate or act on Resident # 249's concern when her hearing aid was reported missing. This affected one of eight of residents reviewed. The facility census was 93. Findings include : Resident #249 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident's son was listed as her power of attorney. The admission care plan dated 01/06/14 indicated Resident #249 had self care deficits and was deaf in her left ear related to a [MEDICAL CONDITION]. Resident #249's inventory of personal effects dated 01/06/14 and signed by the family indicated the resident had a hearing aid for the left ear. Resident #249 was hosptalized on [DATE] and returned to the facility 01/14/14 and the inventory of personal effects indicated the resident returned with a left hearing aid and batteries. Some time after Resident #249's readmission to the facility on 01/14/14 , the resident's left hearing aid was missing. There was no evidence the facility missing item form was completed related to Resident # 249's missing hearing aid. The DON was interviewed on 08/18/2014 11:57 A.M. The DON verified there was no information available that the missing item form was completed when the resident's hearing aid was missing, or that anything had been done to find the missing hearing aid. This deficiency substantiates Complaint Number OH 927.
F 0224 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to prevent the misappropriation of narcotic medication for Resident #91, #86, #2, #34, #5, #107 and #113. This affected seven of seven residents reviewed for misappropriation of medication. Findings include: On 08/14/14 at 6:05 P.M. interview with Registered Nurse (RN) #25 revealed she was a unit manager. RN #25 indicated she had been the primary investigator of an incident of theft of narcotics from residents in the facility involving Licensed Practical Nurse (LPN) #31. RN #25 revealed a concern had been brought to her attention around the middle of July, 2014 when a nurse alleged that LPN #31 was falsely signing her initials on resident medication administration documents. RN #25 stated both she and RN #17 were watching LPN #31 and had come into the facility on [DATE] to gather information. RN #25 stated they found medications signed out for residents too early and found medications in medication cups in the top drawer of the medication cart assigned to LPN #31. Additionally RN #25 indicated the investigation provided information from Resident #91, who was experiencing pain and whom LPN #31 had documented she had administered pain medication to. Resident #91 denied receiving pain medication from LPN #31. During the interview, RN #25 stated LPN #31 was asked to submit to a drug test, which she declined. RN #25 stated LPN #31 subsequently quit and had not been in the facility since the date of the incident on 07/13/14. The facility investigation determined medications, including narcotic medications had been stolen from Resident #91, who voiced pain; Resident #86 who was concerned about the incident; Resident #2, who voiced pain; Resident #34, who voiced pain; Resident #5, who was concerned about the incident; Resident #107, who voiced pain and Resident #113, who did not voice any concerns. The length of time LPN #31 had been stealing medications or the total number of resident's affected could not be determined by the facility investigation. Review of the facility abuse policy, dated 05/31/09 revealed it was the intent of the facility to prevent in any way possible the abuse, mistreatment or neglect of residents or the misappropriation of their property. The policy further included the definition of misappropriation which stated misappropriation of resident's property meant the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. This deficiency substantiates Complaint Number OH 034 and Complaint Number OH 945.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to prevent the misappropriation of narcotic medication for Resident #91, #86, #2, #34, #5, #107 and #113. This affected seven of seven residents reviewed for misappropriation of medication. Findings include: On 08/14/14 at 6:05 P.M. interview with Registered Nurse (RN) #25 revealed she was a unit manager. RN #25 indicated she had been the primary investigator of an incident of theft of narcotics from residents in the facility involving. Licensed Practical Nurse (LPN) #31. RN #25 revealed a concern had been brought to her attention around the middle of July, 2014 when a nurse alleged that LPN #31 was falsely signing her initials on resident medication administration documents. RN #25 stated both she and RN #17 were watching LPN #31 and had come into the facility on [DATE] to gather information. RN #25 stated they found medications signed out for residents too early and found medications in medication cups in the top drawer of the medication cart assigned to LPN #31. Additionally RN #25 indicated the investigation provided information from Resident #91, who was experiencing pain and whom LPN #31 had documented she had administered pain medication to. Resident #91 denied receiving pain medication from LPN #31. The facility investigation determined medications, including narcotic medications had been stolen from Resident #91, who voiced pain; Resident #86 who was concerned about the incident; Resident #2, who voiced pain; Resident #34, who voiced pain; Resident #5, who was concerned about the incident; Resident #107, who voiced pain and Resident #113, who did not voice any concerns. The length of time LPN #31 had been stealing medications or the total number of resident's affected could not be determined by the facility investigation. Review of the facility abuse policy, dated 05/31/09 revealed it was the intent of the facility to prevent in any way possible the abuse, mistreatment or neglect of residents or the misappropriation of their property. The policy further included the definition of misappropriation which stated misappropriation of resident's property meant the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. This deficiency substantiates Complaint Number OH 034 and Complaint Number OH 945.
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.**

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F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure medication adminsitered to Resident #214 was administered in accordance with acceptable nursing standards of practice for medication administration. This affected one resident (Resident #214) of six residents reviewed for unnecessary medication use. Findings include: 1. Review of the facility Grievance Quality Assurance (QA) log revealed two entries related to concerns with medication administration involving Resident #214. An entry, dated 06/13/14 generated by the resident's family related to physician notification of blood sugar and on 05/04/14 related to concerns with medications. Both concerns revealed the nurse's involved were educated and as a resulf of the incident on 06/13/14 a nurse was suspended. Review of a nursing progress note, dated 05/07/14 at 3:24 A.M. as an addendum to 05/05/14 revealed, when giving bedtime (hs) meds on 05/04/14, medications were given to resident (Resident #214) with much help from family. The note indicated the resident was lethargic, not following commands to open mouth to take the medications from the nurse or from a family member. The noye indicated the family member squeezed Resident #214's cheeks togehter to try to get her to open her mouth. Resident #214 eventually opened mouth and the pills were given after approximately 15 mintues of attempting to get the resident to open her mouth. The nursing note indicated Resident #214 then would not swallow the medications. The nurse and family member then coaxed, pleaded, stroked throat, attempted to give water (would not open mouth) to get Resident #214 to swallow medications without success. After approximately 15-20 minutes Resident #214 finally swallowed medications. The entry was documented by RN #27. During the on-site survey, on 08/14/14 a request was made to review the investigation and [MEDICATION NAME] surrounding the grievance/concern filed by the family on 05/04/14 related to medications which resulted in staff re-education. On 08/14/14 at 5:24 P.M. interview with the director of nursing (DON) revealed she was unable to locate both the investigaton and the personnel file for RN #27 and therefore no additional information was available to review during the on-site survey related to this incident. Review of a nursing progress note, completed by Registered Nurse (RN) #18, dated 06/18/14 at 12:30 P.M. as a late entry revealed Resident #214's family told RN #18 on 06/13/14 around 8:30 A.M. that Resident #214's blood sugar that morning had been 60 and the night nurse (RN #26) told the resident to drink a full galss of cranberry juice. RN #18 documented he had been told in report, by RN #26 that Resident #214's blood sugar had been low but when questioned how low, RN #26 told him the blood sugar was 80. RN #18 indicated the resident's 6:00 A.M. scheduled medications were documented as being adminsitered, however her 6:00 A.M. medications had been placed in a cup and put by the resident's window and left for the family to give later. The nursing progress note indicated Resident #214's family was very upset about this and asked to speak to someone in charge. The nursing progress note indicated the unit manager spoke with the resident and family. On 08/14/14 at 3:09 P.M. interview with the DON revealed she was aware of an incident related to Resident #214's family voicing a concern related to the resident's blood sugar not being accurately documented and the physician not being notified of a low blood sugar. The DON indicated the incident had occurred on 05/26/14 when the family said they were told by a nurse the Resident #214's A.M. blood sugar was 80 but in fact it was only 60. The DON stated the family was concerned the resident's medical records had been falsified related to her blood sugar levels. The DON then indicated the incident had not occurred on 05/26/14 but on 06/17/14 and the concern was that the family was told one blood sugar result but the nurse documented a different result. On 07/31/14 at 11:13 A.M. a nursing progress note, documented as a late entry for 07/30/14 at approximately 3:50 P.M. and completed by the DON revealed a meeting had been held with the resident's family and the ombudsman regarding concerns the family had over the nurse assigned to the resident. The family indicated they were unhappy with the nurse and asked the nurse not provide care to the resident. Review of a Grievance/Complaint Report, completed by RN #30 dated 07/26/14 revealed Resident #214's granddaughter stated RN #29 came into the resident's room with 8:00 A.M. medications, insulin, glucometer and blood pressure cuff and said, Here is her meds, I am not allowed in here. The medications were left at the bedside and the family took pictures. The report indicated, LPN #21 went into the room and saw the medications at the bedside. Facility follow up revealed RN #29 was educated. Review of the grievance report revealed no statements had been obtained from LPN #21 or RN #29 related to the incident. Additioanlly, there were no nursing progress notes related to the incident nor was there any information related to why RN #29 would make this statement to Resident #214 or her family or why she would be assigned to care for the resident if the resident/family had requested the nurse not provide care. This incident was not included on the facility Grievance QA Log. On 08/14/14 at 7:05 P.M. interview with RN #26, who routinely worked 7:00 P.M. to 7:00 A.M. revealed she had cared for Resident #214 during her stay in the facility. The RN stated it was common practice to give the resident's medications to her family to administer because it took a long time to give her her morning medications. The RN stated sometimes it would take 15 or 20 minutes just to administer two 6:00 A.M. pills. During the interview, RN #26 verified she was the nurse assigned to administer medications to Resident #214 on 06/13/14. The RN stated she recalled checking the resident's blood sugar that morning and it was 60. The RN stated she got the resident a cranberry juice with three sugar packets and had the resident drink it. The RN stated she got called away to another resident and forgot to document the blood sugar and also did not notify the physician (the resident had an order to notify the physician if her blood sugar was less than 80). The RN stated when she was reviewing the Medication Administration Record [REDACTED]. The RN verified the blood sugar of 80 was not accurate and that the resident's blood sugar that morning was actually 60, which required physician notification which she failed to do. Review of the facility undated policy and procedure related to medication administration revealed it was the policy of the facility that all medications would be administered only as prescribed and only by a licensed or authorized personnel. The policy indicated Never leave medications unattended and Do not leave resident until medication is swallowed, Never leave at bedside or on tray. This deficiency substantiates Complaint Number OH 783.
F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide a restorative nursing program to maintain the current ambulation status for Resident #216. This affected one of three residents reviewed for rehabilitation. Findings include: Resident #216 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 08/13/14 at 9:45 A.M. interview with Resident #216 revealed she independently used the bathroom with her walker. She was observed in bed with oxygen on per nasal cannula via concentrator. On 08/13/14 at 2:15 P.M. Resident #216 was observed wheeling down the hallway in her wheelchair with portable oxygen on per nasal cannula. Review of the physical therapy (PT) note dated 04/17/14 indicated Resident #216 transferred with contact guard assistance. She received PT for therapeutic exercises, neuromuscular re-education, therapeutic activities, transfers, ambulation, bed mobility, balance, safety training and strengthening. PT notes dated 05/08/14 indicated Resident #216 required stand-by assist and supervision for transfers. The PT discharge summary dated 07/17/14 indicated the resident was able to transfer with modified independence with zero percent verbal instructions and cues and ambulated 150 feet with a wheeled walker with distant supervision and modified independent assistance. The discharge plan and instructions recommended a walker for ambulation and a restorative nursing program for strengthening and gait. On 08/14/14 at 1:30 P.M. the director of nursing (DON) verified a restorative assessment or restorative program was not initiated for Resident #216 as recommended by the physical therapist on 07/17/14. This deficiency substantiates Complaint Number OH 034.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #229, who required staff assistance with activities of daily living received assistance with bathing and oral hygiene as necessary and per the resident's preference. This affected one resident (Resident #229) of three residents reviewed for activities of daily living. Findings include: Review of the medical record of Resident #229 revealed the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed the resident was hospitalized from [DATE] until 07/07/14. The resident was re-admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) 3.0 dated 07/14/14 revealed the resident was alert and oriented. Record review revealed the resident was hospitalized again from

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) 07/22/14 to 08/01/14. The resident was readmitted to the facility on [DATE]. Record review revealed on 08/01/14 an alteration in activity of daily living (ADL) function/mobility/self care deficits plan of care was initiated related to decreased strength and endurance, cancer and unsteady gait. The goal developed was for the resident to be clean, dry, odor free and appropriately dressed for the season every day through the next review date of 10/01/14. Review of the interventions contained on the plan of care revealed the only intervention noted was a wheelchair. A second plan of care, dated 08/01/14 with no problem noted revealed an intervention under the area of oral hygiene, noting the resident had his own teeth and A.M. and P.M. care. Review of the nursing progress notes from 08/01/14 through 08/13/14 revealed no documentation related to the delivery of personal care related to activities of daily living. On 08/11/14 at 5:24 P.M. interview with Resident #229 and his spouse, who was present in the room and participated in the interview, revealed the resident required assistance with dressing and grooming including teeth and mouth cleaned (routine oral hygiene). During the interview, the resident's spouse voiced concerns that she did not feel the staff brushed the resident's teeth everyday. The resident's spouse also voiced concerns that the resident had showered daily while at home and that since being admitted to the facility he had only received one shower she could recall. On 08/14/14 at 10:15 A.M. Resident #229 was observed sitting in a chair in his room next to his bed. The resident was observed dressed in his own clothing. Interview with the resident at that time revealed he had been assisted to wash in bed by STNA #22 earlier this date. When asked if he had a shower, the resident stated no he hadn't had a shower and indicated it was easier to get washed up in bed or in the bathroom. When asked if he had brushed his teeth or if the STNA had assisted him to brush his teeth when he was getting cleaned up, he stated no. The resident stated he needed staff to assist with oral care and getting his toothbrush for him and that the STNA had not provided oral care during his personal hygiene on this date. On 08/14/14 at 10:20 A.M. interview with STNA #22 revealed she was assigned to provide care and had assisted Resident #229 with personal care on this date. The STNA stated the resident didn't go to the shower because he had oxygen and it was hard. The STNA stated she recalled one occasion in which the resident was provided a shower since his admission. When asked if the STNA had assisted with oral care as part of the resident's personal care on this date the STNA initially stated she had. When shared the resident voiced he had not received oral care or had his teeth brushed yet this date, the STNA then stated she hadn't assisted with the task as of this time. This deficiency substantiates Complaint Number OH 034.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure interventions were in place and treatments were provided as ordered to promote the healing of Resident #229's pressure ulcers to the bilateral heels and spine. This affected one resident (Resident #229) of four residents reviewed for pressure ulcer development and treatment. Findings include: Review of the medical record of Resident #229 revealed the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed the resident was admitted to the facility with pressure ulcers to his bilateral heels and spine area with treatments initiated at the time of admission. Record review revealed the resident was hospitalized from [DATE] until 07/07/14 and then again from 07/22/14 until 08/01/14. Review of a nursing progress note dated 08/01/14 timed 8:00 P.M. revealed Resident #229 was alert and oriented times three. The note indicated the resident's left heel had a pressure ulcer that measured one centimeter (cm) in length by 1.6 cm with 0.2 cm depth. Resident #229's right heel was noted to have a pressure ulcer that measured 1.4 cm in length by 1.5 cm width with 0.2 cm depth. Two areas were noted to the resident's spine, an upper area, Stage III pressure ulcer measuring 1.5 cm in length by one cm width and a second area measuring 1.2 cm in length by one cm width. Neither of the areas to the spine were assessed to have a depth noted. Review of the re-admission physician orders, dated 08/01/14 revealed an order to elevate heels with a pillow and turn and reposition every two hours. Treatment orders on re-admission, dated 08/01/14 included to cleanse the bilateral heels with soap and water, rinse and dry and apply [MEDICATION NAME] HCS. The treatment was ordered to be completed every other day. A second treatment order, dated 08/01/14 revealed to cleanse the resident's back (spine) ulcers with soap and water, rinse and dry and apply [MEDICATION NAME] and cover with foam dressing. The treatment to the back was ordered to be completed daily. Review of the treatment administration record for August, 2014 revealed no written evidence the treatment to Resident #229's bilateral heels or back (spine) was completed until 08/04/14, three days after the resident was readmitted . There was no written evidence Resident #229 was turned and repositioned every two hours during the day shift from 08/02/14 through 08/10/14 or on 08/12/14. There was no written evidence Resident #229 was turned and repositioned every two hours during the evening shift from 08/06/14 through 08/08/14 or on 08/10/14. Additionally, there was no written evidence Resident #229's heels were elevated with pillows during the day shift from 08/02/14 through 08/10/14 or on 08/12/14. There was no written evidence the resident's heels were elevated with pillows during the evening shift from 08/06/14 through 08/08/14 or on 08/10/14. Record review revealed Resident #229 was not assessed by the wound nurse, Licensed Practical Nurse (LPN) #19 until 08/04/14, three days following the readmission date of [DATE]. On 08/04/14 Resident #229 was assessed to have a Stage III pressure ulcer to the upper-mid vertebrae which measured 1.7 cm in length by 1.1 cm width with 0.3 cm depth, a Stage III pressure ulcer to the right heel measuring one cm in length by 1.5 cm width with 0.4 cm depth, a Stage III pressure ulcer to the left heel measuring one cm in length by one cm in width by 0.3 cm depth and a Stage III pressure ulcer to the lower spine measuring 1.5 cm in length by 1.4 cm width by 0.3 cm depth. On 08/04/14 an order was obtained for skin checks to be completed daily. Review of the treatment administration record revealed no written evidence the skin checks were completed as ordered from 08/08/14 through 08/10/14. On 08/04/14 an order was obtained for bilateral heel protectors to be worn in bed. Review of the treatment administration record revealed no written evidence the heel protectors were applied as ordered from 08/05/14 through 08/10/14 or on 08/12/14. On 08/05/14 the treatment to the resident's bilateral heels was changed from every other day to three times per week. Review of the administration record revealed the treatment was completed on 08/05/14 but then not again until 08/11/14 (six days later). On 08/05/14 the treatment to the resident's spine was changed from daily to three times per week. Review of the administration record revealed the treatment was completed on 08/05/14 but then not again until 08/11/14 (six days later). On 08/11/14 at 3:21 P.M. and on 08/13/14 at 8:10 A.M. Resident #229 was observed in his room in bed with his bilateral heels directly on the mattress. There was no evidence the resident's heels were elevated or he was wearing heel protectors at that time. On 08/13/14 at 2:30 P.M. interview with Licensed Practical Nurse (LPN) #19, the facility wound nurse, revealed she had obtained a new treatment order for the resident's bilateral heels and spine on 08/05/14. The LPN indicated she completed the dressing changes on that date (08/05/14). The LPN verified the treatments were not documented as completed again until 08/11/14. The LPN indicated they should have been changed on 08/08/14. The LPN verified the lack of written evidence the treatments, skin checks and preventative skin measures were in place as ordered from 08/01/14 through 08/13/14 as noted above. On 08/13/14 at 2:40 P.M. LPN #19 was observed completing the dressing change to the resident's bilateral heels and spine areas. The resident was observed in bed without bilateral heels protectors in place at that time. During the observation, LPN #19 verified the resident currently had Stage III pressure ulcers to his bilateral heels and spine area. On 08/14/14 at 10:15 A.M. Resident #229 was observed sitting in a recliner chair in his room. The resident was observed wearing non-skid socks and his bilateral heels were observed resting directly on the foot rest of the chair. The resident's heels were not observed to be elevated on a pillow at that time. This deficiency substantiates Complaint Number OH 668 and Complaint Number OH 981.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident #99 who was identified at high risk for falls had fall prevention interventions in place as ordered by the physician. Harm occurred on 07/11/14 when Resident #99 fell and sustained a subdural hematoma requiring a hospital admission. In addition, the facility failed to ensure adequate supervision was provided to prevent a fall for Resident #122. This affected two of five residents reviewed for falls (Residents #99 and #122). The facility census was 93. Findings include: 1. Resident #99 was admitted to the facility on

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	365853	A. BUILDING _____ B. WING _____	08/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENBRIAR CENTER	8064 SOUTH AVENUE BOARDMAN, OH 44512

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) [DATE] with [DIAGNOSES REDACTED]. On admission Resident #99 was assessed as a high risk for falls. Review of a progress note dated 07/10/14 timed 3:20 P.M., revealed Resident #99 toppled out of chair onto her left side. The resident denied pain and stated she did not fall. The progress note indicated Resident #99 was confused and did not understand her surroundings. As a result of the fall, the physician ordered a low bed and bilateral mats to the floor next to the bed for the resident's safety. Review of a progress note dated 07/11/14, revealed Resident #99 sustained an unwitnessed fall. The note indicated the nurse walked by Resident #99's room and observed her on the floor with staff members administering first-aid. The progress note indicated Resident #99 was actively bleeding from a laceration to the back of her head. Resident #99 was sent to the hospital for evaluation. Review of a progress note dated 07/12/14, revealed Resident #99 was admitted to the hospital with [REDACTED].#99 remained in the hospital until 07/16/14, when she was readmitted to the facility. Review of the facility's incident investigation for the 07/11/14 fall revealed Resident #99's bed was not in the low position, the call light was not in reach and the floor mats were not on the floor on either side of the bed as ordered by the physician for fall prevention interventions. The director of nursing (DON) was interviewed on 08/19/14 at 8:25 A.M. The DON verified Resident # 99 was supposed to have a low bed and floor mats in place as a safety precaution and verified they were not in place at the time of the fall. The DON verified the resident was sent to the hospital on [DATE], as a result of the fall. 2. Resident #122 was admitted on [DATE], with right hip hemiarthroplasty, hypertension, chronic obstructive pulmonary disease, anxiety, and [DIAGNOSES REDACTED]and no longer resided in the facility. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was alert and oriented, required extensive assistance of two persons for bed mobility, transfers, toileting, and hygiene. Resident #122 was frequently incontinent of bowel and bladder. Resident #122 had fallen in the month prior to admission and was assessed to be at high risk for falls. Review of a progress incident note dated 05/22/14 at 6:30 A.M., revealed the nurse was called into Resident #122's room by State tested Nurse Aide (STNA) #33. The resident was sitting on the bathroom floor in the corner across from the toilet and positioned on his left hip/thigh. Resident #122 was assisted off the floor by three staff and placed into a wheelchair. The resident was unable to move his right leg and complained of pain. The nurse assessed the resident, notified the physician, and administered pain medication. The resident was sent to the emergency room for an evaluation and returned with no additional orders. Record review of the 05/22/14 fall investigation revealed STNA #33 stated that after Resident #122 was finished using the commode, she helped him stand up. He was holding onto the guard rails as she provided perineal care. STNA #33 indicated Resident #122 turned and told her he could not stand any longer. STNA #33 tried to direct the turn and sit the resident on the toilet, but he turned around and began slowly sitting. STNA #33 helped Resident #122 to the floor and then proceeded to get the nurse. Interview with Physical Therapy Director, (PT) #34 on 08/14/14 at 3:15 P.M. revealed Resident #122 was evaluated as a maximum assist for transfers on 05/20/14. PT #34 stated that the transfer status of new residents was discussed during the morning meeting and that Resident #34 was assessed by therapy to require two persons to transfer. PT #34 stated Resident #122 was unable to take forward steps due to fear and pain and transferred from the bed to his wheelchair with moderate assistance of two persons. Review of therapy notes dated 05/21/14 revealed Resident #122 was a moderate assist of two persons for toilet transfers. An interview and review of the fall plan of care for Resident #122 was conducted with the DON on 08/14/14 at 4:00 P.M. The plan indicated the resident required one to two persons for transfers. The DON verified the resident should have been transferred by two staff members as assessed by the physical therapist. This deficiency substantiates Complaint Number OH 668 and Complaint Number OH 034.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to maintain a medication error rate of less than five percent. The medication error rate was calculated to be 22.22 percent. This included eight errors of 36 observed medication administration opportunities. This affected three residents (Resident #42, #105 and #1) of six residents observed during the medication administration observation. Findings include: 1. On 08/11/14 at 11:54 A.M. Licensed Practical Nurse (LPN) #15 was observed standing at the medication cart on the 200 hall. Interview with the LPN at that time revealed she was administering medications. The LPN indicated she had medications to administer to Resident #42 that were her morning medications. As the LPN proceeded to prepare the medications, she noted the resident was not in her room and had been taken to the dining room for lunch. The resident was then brought back to her room from the dining room to receive her medications. As the LPN was preparing the medications, Resident #42 repeatedly stated she had been waiting hours for her pills and that she wouldn't be able to eat her lunch because she was getting these pills now, her food would be cold and she was upset regarding the medication administration time. LPN #15 was observed to prepare eight medications, including [MEDICATION NAME] 60 milligrams (mg), [MEDICATION NAME] 325 mg, [MEDICATION NAME] ER ([MEDICATION NAME]) 600 mg, Potassium 20 milliequivants (meq) and a [MEDICATION NAME] ([MEDICATION NAME]) topical patch. The medication administration was completed at 12:16 P.M. and the resident was returned to the dining room for her lunch meal. Review of the current physician medication orders and Medication Administration Record [REDACTED].M. and 10:00 P.M., Klor Con (Potassium) 20 meq to be administered twice a day and scheduled for 10:00 A.M. and 2:00 P.M. and a [MEDICATION NAME] to be applied topically once a daily. The patch was scheduled to be applied at 10:00 A.M. and removed at 10:00 P.M. The resident had a current order for [MEDICATION NAME] 60 mg by mouth every morning and scheduled for 10:00 A.M. A second order for [MEDICATION NAME] was also in place, [MEDICATION NAME] 20 mg which was ordered once daily and scheduled for 2:00 P.M. On 08/11/14 at 6:30 P.M. review of the August, 2014 Medication Administration Record [REDACTED].M. medications were signed as being administered as ordered. There was no indication on the administration record the medications had been administered late. Additionally, the medications that had been scheduled to be administered at 2:00 P.M., including the [MEDICATION NAME] 20 mg and Potassium 20 meq had not been signed that they had been administered. On 08/11/14 at 6:32 P.M. interview with LPN #15 revealed she had administered the resident her [MEDICATION NAME] and Potassium at around 1:30 P.M. The LPN indicated she must have forgot to sign the administration record for the medications. Additional interview, with LPN #15 and Registered Nurse (RN) #17 at that time revealed they were aware the resident's morning medications, scheduled for 10:00 A.M. were administered late, when given after 12:00 P.M. The LPN indicated she had notified the physician, although there was no nursing progress note to reflect the notification. RN #17 indicated a medication error report was completed to reflect the medication errors made by LPN #15. Based on observation of the medication administration there were five observed errors, including [MEDICATION NAME] which was scheduled to be given with breakfast, [MEDICATION NAME] ER which was administered late (scheduled to be administered twice a day at 10:00 A.M. and 10:00 P.M.), [MEDICATION NAME] 60 mg which was administered late (scheduled at 10:00 A.M. and administered after 12:00 P.M. and then again at 1:30 P.M.), Potassium 20 meq which was administered late (scheduled to be administered at 10:00 A.M. and administered after 12:00 P.M. and then again at 1:30 P.M.) and a [MEDICATION NAME] which was administered late (scheduled to be administered at 10:00 A.M.). On 08/11/14 at 6:40 P.M. the regional administrator verified no nursing progress notes had been completed for Resident #42 since 07/21/14. There were no progress notes related to the medication errors or physician notification of the errors. 2. On 08/13/14 at 7:43 A.M. LPN #16 was observed administering medication to Resident #105. Interview with the LPN revealed the resident would be leaving the facility to go to [MEDICAL TREATMENT] around 8:00 A.M. on this date. Interview with the LPN and Resident #105 at the time of the medication administration revealed the resident had already eaten her breakfast and was waiting to leave for [MEDICAL TREATMENT]. Prior to preparing the resident's medication, the LPN was observed to check the resident's blood sugar. The blood sugar was noted to be 129. No insulin was administered at that time. The LPN prepared and administered one oral medication, [MEDICATION NAME] 800 mg. After administering the medication, the LPN indicated she was completed with the resident's medication administration. Record review revealed the resident went to [MEDICAL TREATMENT] three times per week, on Monday, Wednesday and Friday. Review of the resident's current physician medication orders and Medication Administration Record [REDACTED]. The order indicated to notify the physician if the blood sugar was less than 70 or greater than 300. The blood sugar checks were scheduled to be completed at 8:00 A.M. and 4:30 P.M. Record review revealed the resident also had a current physician order to administer insulin, [MEDICATION NAME] N 20 units subcutaneously on Monday, Wednesday and Friday. The insulin medication was scheduled to be administered at 8:00 A.M. Record review revealed there were no physician ordered parameters to hold the insulin based on the resident's blood sugar

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F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) level. A notation completed on the back of the administration record, by LPN #16 revealed the [MEDICATION NAME] N insulin was held on 08/13/14 at 8:00 A.M. because the resident's fasting blood sugar was 129. On 08/13/14 at 10:05 A.M., interview with LPN #16 revealed Resident #105 had an order for [REDACTED]. The LPN verified she did not administer the insulin because the resident's blood sugar was 129. The LPN stated it was nursing judgement not to administer the insulin. When asked if the facility had a policy regarding holding insulin per nursing judgement, she stated she wasn't sure. The LPN stated she would normally hold insulin if the resident's blood sugar was under 100. On 08/13/14 at 11:25 A.M. interview with the DON verified the resident did not have physician ordered parameters for holding her 8:00 A.M. dose of insulin on [MEDICAL TREATMENT] days and the facility did not have a policy regarding holding insulin medication per nursing judgement. 3. On 08/13/14 at 10:08 A.M. LPN #16 was observed administering medications via gastrostomy tube to Resident #1. The LPN was observed to obtain and prepare five medications, including [MEDICATION NAME] one gram which was crushed and dissolved in water and [MEDICATION NAME], a liquid medication of which 15 milliliters (ml) was poured. The label on the [MEDICATION NAME] medication bottle indicated there were 15 mg per one milliliter (15mg/1ml) After preparing the medications, the LPN was observed to enter the resident's room. The resident did not have any enteral feeding infusing at the time of the medication adminsitration. After washing her hands, applying gloves and checking for proper gastrostomy tube placement, at 10:32 A.M. LPN #16 administered the first medication. Each of the medications were administered separately and water was administered between each medication. The medication administration was complete at 10:46 A.M. Review of Resident #1's medical record revealed the resident had a current physician order for [REDACTED].M., 3:00 P.M., 9:00 P.M. and 3:00 A.M. The resident also had a current physician order for [REDACTED]. On 08/13/14 at 11:00 A.M. interview with LPN #16 verified she administered Resident #1's [MEDICATION NAME] medication late. The LPN also verified she administered an incorrect dose of [MEDICATION NAME] to the resident. The LPN verified she poured 15 milliliters of the medication when she should only have poured 10 milliliters. This deficiency substantiates Complaint Number OH 034, Complaint Number OH 945 and Complaint Number OH 783.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to maintain sufficient nursing staff to ensure all residents received adequate, timely and appropriate care and treatment and the necessary services to attain or maintain the highest practicable physical, mental and psychosocial well-being. This affected eight residents (Resident #233, #31, #105, #246, #60, #210, #113, #244 and #121) of 22 residents interviewed, one resident (Resident #229) of two residents whose family members were interviewed, one resident (Resident #42) of six residents who were observed receiving medications and had the potential to affect all residents residing in the facility. The facility census was 93. Findings include: 1. On 08/11/14 and 08/12/14 interviews with seven residents (Resident #233, #31, #105, #246, #60, #210 and #244) revealed concerns related to staffing in the facility. During the resident interview process, each resident was asked, do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time? The following information was provided by the residents interviewed: On 08/11/14 at 12:49 P.M. interview with Resident #60 revealed the resident did not feel there was enough staff in the facility to provide timely assistance. The resident stated he did not feel there was enough staff to assist with passing trays, assist with dining and answer call lights at the same time. The resident stated he often sat in the lounge area by the nurse's station and watched call lights. The resident stated call lights took sometimes up to 30 minutes to be answered. The resident stated sometimes he heard residents yelling for help when their call lights weren't answered. On 08/11/14 at 2:49 P.M. interview with Resident #210 revealed the resident felt there weren't enough staff in the facility to ensure he received timely care and assistance. On 08/11/14 at 3:27 P.M. interview with Resident #31 revealed the resident did not feel there was enough staff available and indicated more staff were needed in the dining room areas to assist with all meals. On 08/11/14 at 3:46 P.M. interview with Resident #246 revealed the resident did not feel there were enough nurses. The resident stated there were not enough staff to assist with medication administration, to call physicians and to ensure the timely administration of medications including pain medications. The resident stated this was a particular problem during the night (7:00 P.M. to 7:00 A.M.) shift. On 08/11/14 at 4:30 P.M. interview with Resident #244 revealed the resident did not feel there were enough staff. The resident revealed having to wait 30 minutes or so to have the call light answered and reported having to wait too long when he had to use the bedpan. On 08/12/14 at 9:22 A.M. interview with Resident #233 revealed the resident felt the facility needed more state tested nursing assistants (STNAs) on all shifts. The resident stated you have to wait sometimes up to a half hour for the call light to be answered. On 08/12/14 at 10:40 A.M. interview with Resident #105 revealed the facility did not have enough staff available and indicated sometimes having to wait over 20 minutes for staff assistance. The following interview was conducted with Resident #229's family. On 08/11/14 at 5:21 P.M. interview with Resident #229's spouse revealed concerns related to the facility staffing. The resident's spouse indicated she did not feel there was enough working to provide timely care. The resident's spouse indicated frequently when she came to visit she couldn't find staff to assist. Especially around dinner and meal times, it was difficult to find staff to assist the resident in her room. The resident's spouse stated staffing concerns occurred on all shifts but seemed worse on the weekends. The resident's spouse also reported one day last week when she came to visit, the resident was in the bathroom and indicated the resident waited for 20 minutes in the bathroom for assistance to be provided. On 08/13/14 at 11:10 A.M. interview with Resident #113 revealed concerns related to medications not being administered on time. The resident stated medications were sometimes given late or not given at all because the routine staff were off and the staff who replaced them didn't know what to do. The resident voiced concerns that pain medication was not always administered timely after requesting the medication. The resident shared an incident that had occurred recently in which he requested his evening medications at around 9:30 P.M. The resident stated at 11:00 P.M. he still had not received his medications and was then told the nurse had left the unit and went to another unit. The resident was concerned and upset that medications were not being administered timely and related this concern to staffing. 2. On 08/11/14 at 11:54 A.M. Licensed Practical Nurse (LPN) #15 was observed standing at the medication cart on the 200 hall (South nursing unit). Interview with the LPN at that time revealed she was administering medications. The LPN indicated she had medications to administer to Resident #42 that were her morning medications. As the LPN proceeded to prepare the medications, she noted the resident was not in her room and had been taken to the dining room for lunch. The resident was then brought back to her room from the dining room to receive her medications. As the LPN was preparing the medications, Resident #42 repeatedly stated she had been waiting hours for her pills and that she wouldn't be able to eat her lunch because she was getting these pills now, her food would be cold and she was upset regarding the medication administration time. LPN #15 was observed to prepare eight medications, including [MEDICATION NAME] 60 milligrams (mg), [MEDICATION NAME] 325 mg, [MEDICATION NAME] ER ([MEDICATION NAME]) 600 mg, Potassium 20 milliequivants (meq) and a [MEDICATION NAME] ([MEDICATION NAME]) topical patch. The medication administration was completed at 12:16 P.M. and the resident was returned to the dining room for her lunch meal. Review of the resident's current physician medication orders and Medication Administration Record [REDACTED]. The resident had a current order for [MEDICATION NAME] ER 600 mg to be administered twice a day and scheduled for 10:00 A.M. and 10:00 P.M. The resident had a current order for Klor Con (Potassium) 20 meq to be administered twice a day and scheduled for 10:00 A.M. and 2:00 P.M. The resident had a current order for [MEDICATION NAME] 60 mg by mouth every morning and scheduled for 10:00 A.M. A second order for [MEDICATION NAME] was also in place, [MEDICATION NAME] 20 mg which was ordered once day and scheduled for 2:00 P.M. The resident also had an order for [REDACTED].M. and removed at 10:00 P.M. On 08/11/14 at 6:30 P.M. review of the August, 2014 Medication Administration Record [REDACTED].M. medications were signed as being administered as ordered. There was no indication on the administration record the medications had been administered late. Additionally, the medications that had been scheduled to be administered at 2:00 P.M., including the [MEDICATION NAME] 20 mg and Potassium 20 meq had not been signed that they had been administered. On 08/11/14 at 6:32 P.M. interview with LPN #15 revealed she had administered the resident her [MEDICATION NAME] and Potassium at around 1:30 P.M. The LPN indicated she must have forgot to sign the administration record for the medications. Additional interview, with LPN #15 and Registered Nurse (RN) #17 at that time revealed they were aware the resident's morning medications, scheduled for 10:00 A.M. were administered late, when given after 12:00 P.M. The LPN indicated she had notified the physician, although there was no nursing progress note to reflect the notification completed as of this time. RN #17 indicated a medication error report was completed to reflect the medication errors made

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) by LPN #15. Based on observation of the medication administration there were five observed errors, including [MEDICATION NAME] which was scheduled to be given with breakfast, [MEDICATION NAME] ER which was administered late (scheduled to be administered twice a day at 10:00 A.M. and 10:00 P.M.), [MEDICATION NAME] 60 mg which was administered late (scheduled at 10:00 A.M. and administered after 12:00 P.M. and then again at 1:30 P.M.), Potassium 20 meq which was administered late (scheduled to be administered at 10:00 A.M. and administered after 12:00 P.M. and then again at 1:30 P.M.) and a [MEDICATION NAME] which was administered late (scheduled to be administered at 10:00 A.M.). 3. On 08/14/14 at 7:05 P.M. interview with RN #26 revealed she had started working at the facility in December, 2013. The RN indicated she worked the 7:00 P.M. to 7:00 A.M. shift on the Providence (200 unit). RN #26 indicated she was usually the only RN in the facility when she worked so she was responsible for completing any intravenous (IV) medication administrations or IV therapy and any other tasks that only an RN could complete. RN #26 stated there were typically two other nurses working with her during the 7:00 P.M. to 7:00 A.M. shift for approximately 100 residents. The RN voiced concerns that medications were administered late if there were new admissions who came resulting in the nurse having to stop the medication pass. Additionally, during the interview, RN #26 shared she had frequently left A.M. medications with Resident #214's family, who stayed with the resident, to administer because it took 15-20 minutes to administer two A.M. medications to the resident. The RN stated it took a long time to administer the medications. 4. Resident #121 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was receiving physical therapy, waiting for a prosthetic leg, and expected to return to the community. Review of the comprehensive Minimum Data Set 3.0 ((MDS) dated [DATE] revealed Resident #121 required extensive assistance with two person physical assist in bed mobility, transfers and toilet use and had no cognitive impairment. During interview on 08/13/14 at 9:15 A.M., Resident #121 stated resident's never get fresh water and staff were just filling water pitchers because the State survey agency was in the facility. Resident #121 stated night shift typically filled the pitchers and they would not be filled again until the following night. The resident also stated they had to wait a long time before someone comes after using the call light. Resident #121 continued stating the STNAs always say they are too busy and cannot get their work done. The resident stated on one occasion, the STNAs had not cleaned up after his bath and a staff member brought in a meal tray and set it on the bedside table next to the dirty bath water. Resident #121 indicated on two occasions it took staff between 25 to 55 minutes to return to remove him from the bedpan. The resident also stated approximately two weeks ago after returning from a leave of absence in the evening his bed was completely stripped and it took 20 minutes before staff made the bed and assisted him into it. 5. On 08/14/14 at 8:14 A.M. STNA #53 was asked if there was enough staff to complete assignments and responded honestly, sometimes no . The STNA stated call offs are handled by pulling staff from another unit and they sometimes work short until management can get additional staff to come in. On 08/14/14 at 8:24 A.M. RN #25 was asked if the STNAs were able to complete their assignments and responded our regular staff are ok with finishing their assignments, however, the newer people have some difficulty because they are not used to the work load. On 08/18/14 at 10:45 A.M. STNA #54 was asked if staff ever work short and responded sometimes we do work short and mostly it's on the weekends. If we are short staffed, it is almost impossible to finish my assignment. Review of the Resident Council minutes dated 04/29/14 included resident complaints of staff not coming into resident rooms as often as they should to check on them. Documentation was noted that the director of nursing was aware of the complaints. Further review of the Resident Council minutes from 05/2014 to 07/2014 had no follow up documentation addressing the complaints. This deficiency substantiates Complaint Number OH 034, Complaint Number OH 945 and Complaint Number OH 911.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to meet the pharmaceutical needs of all residents, including Resident #42, #105, #113, #38, #63, #250, #214, #91, #86, #2, #34, #5, #107, #128, #217 and #238 to ensure the proper, accurate and timely administration of medication and blood sugar monitoring was completed. This affected 16 residents of 19 residents reviewed for misappropriation of narcotic medications, medication administration and/or unnecessary medication use. Findings include: 1. On 08/11/14 at 11:54 A.M. Licensed Practical Nurse (LPN) #15 was observed standing at the medication cart on the 200 hall (South nursing unit). Interview with the LPN at that time revealed she was administering medications. The LPN indicated she had medications to administer to Resident #42 that were her morning medications. As the LPN proceeded to prepare the medications, she noted the resident was not in her room and had been taken to the dining room for lunch. The resident was then brought back to her room from the dining room to receive her medications. As the LPN was preparing the medications, Resident #42 repeatedly stated she had been waiting hours for her pills and that she wouldn't be able to eat her lunch because she was getting these pills now, her food would be cold and she was upset regarding the medication administration time. LPN #15 was observed to prepare eight medications, including Lasix 60 milligrams (mg), Ferrous Sulfate 325 mg, Guaifenesin ER (Mucinex) 600 mg, Potassium 20 milliequivants (meq) and a Lidoderm (Lidocaine) topical patch. The medication administration was completed at 12:16 P.M. and the resident was returned to the dining room for her lunch meal. Review of Resident #42's current physician medication orders and medication administration record (MAR) revealed the following. The resident had a current order for Ferrous Sulfate 325 mg to be administered one tablet by mouth in the morning with breakfast. The resident had a current order for Guaifenesin ER 600 mg to be administered twice a day and scheduled for 10:00 A.M. and 10:00 P.M. Resident #42 had a current order for Klor Con (Potassium) 20 meq to be administered twice a day and scheduled for 10:00 A.M. and 2:00 P.M. The resident had a current order for Lasix 60 mg by mouth every morning and scheduled for 10:00 A.M. A second order for Lasix was also in place, Lasix 20 mg which was ordered once day and scheduled for 2:00 P.M. The resident also had an order for [REDACTED]. The patch was scheduled to be applied at 10:00 A.M. and removed at 10:00 P.M. On 08/11/14 at 6:30 P.M. review of the August, 2014 MAR for 08/11/14 revealed all of the above 10:00 A.M. medications were signed as being administered as ordered. There was no indication on the MAR the medications had been administered late. Additionally, the medications that had been scheduled to be administered at 2:00 P.M., including the Lasix 20 mg and Potassium 20 meq had not been signed that they had been administered. On 08/11/14 at 6:32 P.M. interview with LPN #15 revealed she had administered the resident her Lasix and Potassium at around 1:30 P.M. The LPN indicated she must have forgot to sign the MAR for the medications. Additional interview, with LPN #15 and Registered Nurse (RN) #17 at that time revealed they were aware Resident #42's morning medications, scheduled for 10:00 A.M. were administered late, when given after 12:00 P.M. The LPN indicated she had notified the physician, although there was no nursing progress note to reflect the notification completed as of this time. RN #17 indicated a medication error report was completed to reflect the medication errors made by LPN #15. Based on observation of the medication administration there were five observed errors, including Ferrous Sulfate which was scheduled to be given with breakfast, Guaifenesin ER which was administered late (scheduled to be administered twice a day at 10:00 A.M. and 10:00 P.M.), Lasix 60 mg which was administered late (scheduled at 10:00 A.M. and administered after 12:00 P.M. and then again at 1:30 P.M.), Potassium 20 meq which was administered late (scheduled to be administered at 10:00 A.M. and administered after 12:00 P.M. and then again at 1:30 P.M.) and a Lidoderm patch which was administered late (scheduled to be administered at 10:00 A.M.). Additionally, review of Resident #42's August, 2014 MAR revealed the resident did not receive her Ferrous Sulfate, Lasix 10:00 A.M. or 2:00 P.M., Guaifenesin ER or Klor-Con (Potassium) as ordered on [DATE]. The resident did not receive her Synthroid medication as ordered on [DATE]. On 08/11/14 at 6:40 P.M. the regional administrator verified no nursing progress notes had been completed for Resident #42 since 07/21/14. There were no progress notes related to the medication errors, physician notification of the errors or entries related to why the medications were not administered as ordered on [DATE] or 08/10/14. 2. On 08/13/14 at 7:43 A.M. LPN #16 was observed administering medication to Resident #105. Interview with the LPN revealed the resident would be leaving the facility to go to hemodialysis around 8:00 A.M. on this date. Interview with the LPN and Resident #105 at the time of the medication administration revealed the resident had already eaten her breakfast and was waiting to leave for hemodialysis. Prior to preparing the resident's medication, the LPN was observed to check the resident's blood sugar. The blood sugar was noted to be 129. No insulin was administered at that time. The LPN prepared and administered one oral medication, Renvela 800 mg. After administering the medication, the LPN indicated she had completed Resident #105's medication administration. Record review revealed the resident went to hemodialysis three times per week, on Monday, Wednesday and Friday. Review of the

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	365853	A. BUILDING _____ B. WING _____	08/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) resident's current physician medication orders and MAR revealed the resident had an order for [REDACTED]. The order indicated to notify the physician if the blood sugar was less than 70 or greater than 300. The blood sugar checks were scheduled to be completed at 8:00 A.M., 4:30 P.M. and 9:30 P.M. Record review revealed the resident also had a current physician order to administer insulin, Humulin N 20 units subcutaneously on Monday, Wednesday and Friday and Humulin N 36 units on Tuesday, Thursday, Saturday and Sunday. The insulin medication was scheduled to be administered at 8:00 A.M. Record review revealed there were no physician ordered parameters to hold the insulin based on the resident's blood sugar level. A notation completed on the back of the MAR by LPN #16 revealed the Humulin N insulin was held on 08/13/14 at 8:00 A.M. because the resident's fasting blood sugar was 129. On 08/07/14 at 8:00 A.M. Resident #105's blood sugar was noted to be 324. There was no written evidence on the MAR or in the nursing progress notes that the physician was notified of the resident's blood sugar as ordered. On 08/13/14 at 10:05 A.M., interview with LPN #16 revealed Resident #105 had an order for [REDACTED].M. The LPN verified she did not administer the insulin because the resident's blood sugar was 129. The LPN stated it was nursing judgement not to administer the insulin. When asked if the facility had a policy regarding holding insulin per nursing judgement, she stated she wasn't sure. The LPN stated she would normally hold insulin if the resident's blood sugar was under 100. Review of the MAR with the LPN #16 at that time revealed on 08/08/14 at 8:00 A.M. the resident's blood sugar was 76 and her insulin was administered. On 08/13/14 at 11:25 A.M. interview and observation of Resident #105's medical record with the director of nursing (DON) revealed discrepancies between the resident's current physician ordered medications and MARs from July, 2014 and August, 2014 related to Tylenol and Renvela medications and insulin orders. The DON indicated the physician should be contacted and clarification obtained. During the interview, the DON verified Resident #105 did not have physician ordered parameters for holding her 8:00 A.M. dose of insulin on hemodialysis days and the facility did not have a policy regarding holding insulin medication per nursing judgement. The DON verified on 08/08/14 a nurse administered the 20 units of insulin as ordered when the resident had a blood sugar of 76 but on 08/06/14 and 08/13/14 it was held for blood sugars of 100 and 129 respectively. The discrepancy noted with Resident #105's ordered Tylenol of 650 mg three times per day was related to whether the medication should be held on dialysis days (all three doses) which had been done from 08/01/14 through 08/13/14 or to hold only the afternoon dose on dialysis days, which had been done in July, 2014. A current physician order, dated 05/20/14 indicated to hold the afternoon dose of Tylenol only on dialysis days. It could also not be determined whether the Renvela 800 mg three times per day was to be held on dialysis days or whether to only hold the afternoon dose of the medication. Additionally Resident #105 had an order for [REDACTED].M.). Review of the August, 2014 administration record revealed Resident #105's blood sugar was not checked at 9:00 P.M. on 08/06/14 or 08/08/14. On 08/13/14 at 11:55 A.M. interview with the DON verified the insulin medication should have been administered to Resident #105 on 08/13/14 as the resident did not have any parameters to hold at the time of the administration and then once parameters were obtained, the order was to hold if less than 100. The DON verified a clarification had also been written to hold the resident's Tylenol (all three doses) on dialysis days, which resulted in medication errors during the month of July, 2014. The DON also verified the lack of written evidence to determine the physician was notified on 08/07/14 when the resident's 8:00 A.M. blood sugar was 324. 3. Review of Resident #38's MAR revealed the resident had a current physician order for [REDACTED]. The order indicated to notify the physician if the blood sugar was less than 70 or greater than 300. The blood sugar checks were scheduled to be completed at 7:00 A.M. and 4:30 P.M. Review of the August, 2014 MAR revealed no evidence the resident's blood sugar was checked as ordered on [DATE] at 7:00 A.M. or on 08/09/14 at 7:00 A.M. On 08/07/14 at 7:00 A.M., 08/06/14 at 4:30 P.M. and on 08/01/14 at 4:30 P.M. the nurse signed that the blood sugar was checked. However, there were no results documented. On 08/13/14 at 10:49 A.M. interview with LPN #16 verified the lack of written evidence that Resident #38's blood sugar was checked per order as noted above. The LPN indicated she was the nurse who signed that she checked the resident's blood sugar on 08/01/14 and 08/06/14 at 4:30 P.M. and didn't document the blood sugar results. 4. On 08/13/14 at 11:10 A.M. during an interview with Resident #113 the resident voiced concerns related to medication administration. The resident shared he had missed doses of medications or received medications late. The resident indicated he felt the medication issues were occurring either because there weren't enough staff in the facility or the staff weren't properly trained. Resident #113 stated he noticed issues with his medications not being given as ordered when the regular nurse for the unit wasn't working, either because of vacation or being on sick leave and the facility not replacing the nurse timely. The resident stated there had been occasions when he did not receive pain medication timely after asking for it. Resident #113 stated, the other night around 9:30 P.M. he asked for his evening medications. The resident stated at 11:00 P.M. he still hadn't received the medications and when he asked again, he was told the nurse had left the unit. Resident #113 voiced concern related to the lack of timely medication administration. 5. On 08/14/14 at 8:02 A.M. LPN #20 was observed administering medications to Resident #63. During the medication administration, the LPN was observed administering the narcotic pain medication, Norco 10-325 mg. The LPN indicated the resident had an order for [REDACTED]. Review of Resident #63's current physician orders revealed an order for [REDACTED]. Review of the MAR for August, 2014 and the corresponding controlled substance record revealed discrepancies related to when the medication was signed out for the resident on the controlled substance record and when the medication was actually administered to the resident according to the MAR. Review of the controlled substance record revealed the medication was signed out for Resident #63 on 08/12/14 at 11:00 A.M., 08/05/14 at 12:00 P.M., 08/05/14 at 6:00 P.M., 08/06/14 at 6:00 A.M., 08/06/14 at 1:00 P.M., 08/07/14 at 12:30 A.M., 08/07/14 at 1:00 P.M. and on 08/12/14 at 2:00 P.M. However, none of the doses were documented as administered to Resident #63 on the MAR. Additionally, on 08/10/14 Norco 10-325 was signed out twice for Resident #63, at 4:15 P.M. and at 10:15 P.M. The MAR reflected it was administered on that date at 12:15 P.M. and 6:10 P.M. On 08/14/14 at 9:00 A.M. interview with the director of nursing (DON) verified the controlled substance record and the medication administration record for Resident #63's prn Norco medication did not match. The DON verified the above dates and times in which the medication was signed out on the controlled substance record for the resident, but was not documented it had been administered to the resident. 6. Record review revealed Resident #250 was re-admitted to the facility on [DATE] following a hospitalization . Record review revealed the resident had an order for [REDACTED]. On 08/12/14 an additional order for Percocet 5-325 mg was obtained and it was to be administered one every four hours routinely. On 08/14/14 at 7:50 A.M. LPN #21 indicated she was going to administer Resident #250 his pain medication. During the administration of the medication, LPN #21 noted Resident #250 had two different pharmacy cards for the Percocet medication, one for the prn dose and one for the routine dose. LPN #21 indicated it did not matter which card she took the medication from for the administration so long as it was signed out. Review of the MAR and the controlled substance records from 08/09/14 through 08/14/14 revealed discrepancies related to when the medication was signed out for Resident #250 on the controlled substance record and when the medication was actually administered to the resident per the MAR. Review of the controlled substance record for the Percocet 5-325 mg, one tab every four hours revealed the sheet was dated 08/12/14. This controlled substance record should have correlated with the routine Percocet order. However, the medication was only signed out for the resident on three occasions, on 08/13/14 at 9:30 A.M., 08/13/14 at 1:00 P.M. and on 08/14/14 at 7:53 A.M. A fourth notation on the controlled substance record revealed the medication was signed out on 08/13/14 at 5:00 P.M. but then contained a line through it with a note that said error. The MAR revealed Resident #250 received the routine Percocet on 08/12/14 at 8:00 P.M., on 08/13/14 at 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M. and on 08/14/14 at 12:00 A.M., 4:00 A.M. and 8:00 A.M. Review of the MAR for the Percocet 5-325 mg, one tablet every six hours as needed revealed the staff documented the medication was administered on 08/09/14 at 5:00 A.M., 08/10/14 6:30 A.M., 08/11/14 at 9:15 A.M., 08/12/14 at 1:00 A.M., 08/12/14 at 12:00 P.M. and 08/13/14 at either 9:00 A.M. or 9:30 A.M. (unable to read) per the medication administration record. However, the controlled substance record revealed the medication was signed out for the resident on 08/09/14 at 3:00 A.M., on 08/09/14 5:00 A.M., on 08/11/14 at 3:00 P.M. and on 08/12/14 at 3:30 P.M. On 08/13/14 the MAR was signed that the medication was administered to the resident seven times (including six routine doses at 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M. and one as needed dose either at 9:00 A.M. or 9:30 A.M.) However, the medication was only signed out for the resident five times. There was no record of the 4:00 P.M. dose being administered. On 08/14/14 at 9:00 A.M. interview and review of Resident #250's MAR and controlled substance record with the DON revealed staff were not maintaining separate documentation and administration of the routine and as needed Percocet medication for the resident. The DON also verified the discrepancies between the dates/times the medication was signed out for the resident per the controlled substance record and the dates/times the medication was documented as being administered to the resident per the MAR as noted above. 7. Review of the facility Grievance Quality Assurance (QA) log revealed two entries related to concerns with medication administration involving Resident #214. An entry, dated 06/13/14 generated by the resident's family related to physician notification of blood sugar and on 05/04/14

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	365853	A. BUILDING _____ B. WING _____	08/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENBRIAR CENTER	8064 SOUTH AVENUE BOARDMAN, OH 44512

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F 0425 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) related to concerns with medications. Both concerns revealed the nurse's involved were educated and as a result of the incident on 06/13/14 nurse was suspended. Review of a nursing progress note, dated 05/07/14 at 3:24 A.M. as an addendum to 05/05/14 revealed, when giving bedtime (hs) meds on 05/04/14, medications were given to resident (Resident #214) with much help from family. The note indicated the resident was lethargic, not following commands to open mouth to take the medications from the nurse or from a family member. The note indicated the family member squeezed Resident #214's cheeks together to try to get her to open her mouth. Resident #214 eventually opened mouth and the pills were given after approximately 15 minutes of attempting to get the resident to open her mouth. The nursing note indicated Resident #214 then would not swallow the medications. The nurse and family member then coaxed, pleaded, stroked throat, attempted to give water (would not open mouth) to get Resident #214 to swallow medications without success. After approximately 15-20 minutes Resident #214 finally swallowed medications. The entry was documented by RN #27. During the on-site survey, on 08/14/14 a request was made to review the investigation and circumstances surrounding the grievance/concern filed by the family on 05/04/14 related to medications which resulted in staff re-education. On 08/14/14 at 5:24 P.M. interview with the DON revealed she was unable to locate both the investigation and the personnel file for RN #27 and therefore no additional information was available to review during the on-site survey related to this incident. Review of a nursing progress note, completed by RN #18, dated 06/18/14 at 12:30 P.M. as a late entry note revealed Resident #214's family told the nurse on 06/13/14 when he did his daily assessment and vital signs around 8:30 A.M. that Resident #214's blood sugar that morning had been 60 and the night nurse (RN #26) told the resident to drink a full glass of cranberry juice. RN #18 documented he had been told in report, by RN #26 that Resident #214's blood sugar had been low but when questioned how low, RN #26 told him the blood sugar was 80. RN #18 indicated Resident #214's 6:00 A.M. scheduled medications were documented as being administered, however her 6:00 A.M. medications had been placed in a cup and put by the window and left with the family to give later. The nursing progress note indicated Resident #214's family was very upset about this and asked to speak to someone in charge. The nursing progress note indicated the unit manager went to speak with the resident and family. On 08/14/14 at 3:09 P.M. interview with the DON verified the incident related to Resident #214's family voicing a concern related to the resident's blood sugar not being accurately documented and the physician not being notified of a low blood sugar. On 07/31/14 at 11:13 A.M. a nursing progress note, documented as a late entry for 07/30/14 at approximately 3:50 P.M. and completed by the DON revealed a meeting had been held with the resident's family and the ombudsman regarding concerns the family had over a nurse assigned to the resident. The family indicated they were unhappy with the nurse and asked the nurse not provide care to the resident. The note indicated the nurse had been educated regarding concerns the family had on Saturday when the concern had occurred and was immediately addressed by the RN supervisor at the time of the incident. The note indicated the DON discussed with the family the education that was given to the nurse and that the facility would try to have another nurse administer medications to the resident. Review of a Grievance/Complaint Report, completed by RN #30 dated 07/26/14 revealed Resident #214's granddaughter stated RN #29 came into the resident's room with 8:00 A.M. medications, insulin, glucometer and blood pressure cuff and said, Here is her meds, I am not allowed in here. The medications were left at the bedside. The report indicated, LPN #21 went into the room and saw the medications at the bedside. On 08/14/14 at 7:05 P.M. interview with RN #26, who routinely worked 7:00 P.M. to 7:00 A.M. revealed she had cared for Resident #214 during her stay in the facility. The RN stated it was common practice to give the resident's medications to her family to administer because it took a long time to give her her morning medications. The RN stated sometimes it would take 15 or 20 minutes just to administer two 6:00 A.M. pills. During the interview, RN #26 verified she was the nurse assigned to administer medications to Resident #214 on 06/13/14. The RN stated she recalled checking the resident's blood sugar that morning and it was 60. The RN stated she got the resident a cranberry juice with three sugar packets and had the resident drink it. The RN stated she got called away to another resident and forgot to document the blood sugar and also did not notify the physician (the resident had an order to notify the physician if her blood sugar was less than 80). The RN stated when she was reviewing the medication administration record before she left for the day she realized she had not documented the resident's blood sugar and couldn't remember what it was, so she documented it was 80. The RN verified the blood sugar of 80 was not accurate and that the resident's blood sugar that morning was actually 60, which required physician notification which she failed to do. Review of the facility undated policy and procedure related to medication administration revealed it was the policy of the facility that all medications would be administered only as prescribed and only by a licensed or authorized personnel. The policy indicated Never leave medications unattended and Do not leave resident until medication is swallowed, Never leave at bedside or on tray. 8. On 08/14/14 at 6:05 P.M. interview with RN #25 revealed she was the unit manager on the Regency unit. The RN indicated she had been the primary investigator of an incident of theft of narcotics from residents in the facility involving LPN #31. RN #25 revealed a concern had been brought to her attention around the middle of July, 2014 when a nurse alleged that LPN #31 was falsely signing her initials on residents' Medication Administration Records. RN #25 stated both she and RN #17 were watching LPN #31 and had come into the facility on [DATE] to gather information. RN #25 stated they found medications signed out for residents too early and found medications in medication cups in the top drawer of the medication cart assigned to LPN #31. Additionally, the RN indicated the investigation provided information from Resident #91, who was experiencing pain and whom LPN #31 had documented she had administered pain medication to. However, Resident #91 denied receiving pain medication from the nurse. During the interview, RN #25 stated LPN #31 was asked to submit to a drug test, which she declined. The LPN subsequently quit and had not been in the facility since the date of the incident (07/13/14), per RN #25. The facility investigation determined medications, including narcotic medications had been stolen from Resident #91, who voiced pain; Resident #86 who was concerned about the incident; Resident #2, who voiced pain; Resident #34, who voiced pain; Resident #5, who was concerned about the incident; Resident #107, who voiced pain and Resident #113, who did not voice any concerns. Based on the facility investigation, the length of time LPN #31 had been stealing medications or the total number of resident's affected could not be determined. Review of documentation, provided from the local police department, dated 07/21/14 revealed the facility filed a theft of dangerous drugs complaint. Staff supervisors discovered erroneous information recorded in patients charts in reference to disbursed prescribed medication. The nursing supervisor further investigated and learned that controlled narcotic medication prescribed to patients were removed from medication carts prior to disbursement and patient chart notes were then entered as if the disbursements were delivered and prescribed. 9. Review of Resident #128's medical record including physician orders and MARs for August, 2014 revealed on 08/12/14 a physician order was obtained for the antibiotic medication, Vancomycin 250 milligrams to be administered orally four times per day for seven days. Review of the MAR revealed the first dose of the medication was not administered until 08/14/14 at 12:00 A.M. On 08/18/14 at 2:44 P.M. interview with RN #17 revealed she was the nurse who obtained the order on 08/12/14 for the antibiotic for Resident #128. RN #17 stated she had assessed the resident and felt the resident had clostridium difficile, which he had been treated for [REDACTED].#17 stated the nurse who was working on the floor did not follow through with the order and therefore it was not obtained from the pharmacy timely. RN #17 verified the delay in the start of treatment and verified the medication, which was ordered on [DATE] was not started until 08/14/14. 10. Resident #238 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MAR for July and August, 2014 revealed medications were not administered as ordered by the physician. Gabapentin (an anticonvulsant and analgesic) 600 milligrams (mg) oral was ordered three times a day. There was no evidence that six doses were administered as ordered in July, 2014. Humulin R insulin (a medication to regulate blood sugar levels) subcutaneously was ordered per sliding scale according to blood sugars three times a day before meals. There was no evidence that nine blood sugars in July, 2014 and one blood sugar in August, 2014 were completed as ordered. An albuterol inhaler (used for the treatment of [REDACTED]. There was no evidence that 16 doses were administered as ordered in July, 2014. Lactobacillus (a supplement to aid digestion) one tablet was ordered once a day orally. There was no evidence that 11 doses in July, 2014 and 2 doses in August, 2104 were administered as ordered. Methocarbamol (a muscle relaxant) 500 mg orally was ordered three times a day. There was no evidence that 8 doses in July, 2104 and one dose in August, 2014 were administered as ordered. Famotidine (an acid reducer) 20 mg orally was ordered twice a day. There was no evidence that 6 doses in July, 2104 and one dose in August, 2104 were administered as ordered. Colace (a stool softener) 100 mg orally was ordered twice a day. There was no evidence that two doses in July 2014 and two doses in August 2104 were administered as ordered. Venlafaxine (an antidepressant) 37.5 mg two tablets were ordered twice a day. There was no evidence that one dose in July 2014 and two doses in August 2104 were administered as ordered. Tamulosin (a medication for treatment of [REDACTED]. There was no evidence that one dose in July, 2014 was administered as ordered. Solifenacin (for treatment of [REDACTED]. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365853	A. BUILDING _____ B. WING _____	08/19/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) evidence that one dose in July, 2014 was administered as ordered. Bisacodyl (a laxative) rectal suppository 10 mg was ordered daily. There was no evidence that 12 doses in August, 2104 were administered as ordered. Zolpidem tartrate (a hypnotic) 5 mg orally was ordered daily at bedtime. There was no evidence that three doses in August, 2104 were administered as ordered. The findings were verified with the DON on 08/14/14 at 11:15 A.M. 11. Resident #217 was admitted [DATE] with [DIAGNOSES REDACTED]. The physician ordered chest X-ray completed on 08/01/14 revealed patchy bilateral infiltrate with increased amount on the left side. On 08/01/14 the physician ordered Levaquin (an antibiotic) 500 milligrams (mg) to be administered intravenously (IV) daily for five days and then an oral dosage for ten additional days. Review of the MAR revealed Resident #217 received his first dose of IV Levaquin on 08/03/14. In addition there was no evidence Resident #217 received the 08/04/14 dose of IV Levaquin. The DON was interviewed on 08/18/14 at 2:10 P.M. and verified the above findings. This deficiency substantiates Complaint Number OH 034, Complaint Number OH 945 and Complaint Number OH 783.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, The facility failed to accurately account for narcotic medications, dispose of expired medication and dispose of medications appropriately when residents were discharged . This affected Residents # 26, #97, #103, #121, #194, #240, #241, #251, #252, #253 and #254. The facility census was 93. Findings include : The facility's medication carts and rooms were observed during the annual survey with the following findings: 1. The low number medication cart on the Regency unit was examined with Licensed Practical Nurse (LPN) #15 on [DATE] at 6:00 P.M. Nine loose unidentified pills were in the drawers of the medication cart. The findings were verified with LPN #15 at 6:25 P.M. 2. The center hall low number medication cart on the Providence unite was examined with RN # 17 on [DATE] at 3:00 P.M. The was a medication card of hydromorphone (a narcotic analgesic) two milligram (mg) tablets for Resident #252 in the medication cart. The controlled substance record indicated there was three pills left on the card, however the card contained two pills. RN # 17 verified the controlled substance record did not match the amount of medication in the card. A medication card of hydrocodone/ibuprofen (a narcotic analgesic) 7.5 mg/200 mg for Resident # 26 contained four pills. The corresponding controlled substance record indicated there should be five pills. RN # 17 verified the controlled substance record did not match the amount of medication in the card. 4. The Providence unit south medication cart was examined with LPN # 20 on [DATE] at 3:09 P.M. A medication card of alprazolam (an anti-anxiety medication) two mg for Resident # 251 contained four pills. The corresponding controlled substance record indicated there should be five pills. LPN # 20 verified the controlled substance record did not match the amount of medication in the card. A medication card of hydrocodone/acetaminophen 7.5 mg/300 mg (a narcotic analgesic) for Resident # 103 contained 10 pills. The corresponding controlled substance record indicated there should be 11 pills. LPN # 20 verified the controlled substance record did not match the amount of medication in the card. Observation on [DATE] was made of a vial of Aplisol (tuberculin) dated as opened on [DATE] and a vial of Lantus insulin for Resident #121 dated as opened on [DATE]. LPN # 20 verified the medications were supposed to be discarded 30 days after opening. 5. The Providence unit north medication cart was examined with LPN # 36 on [DATE] at 3:59 P.M. The following narcotic medications for residents no longer in the facility remained in the cart: a. Resident #241; hydrocodone/ acetaminophen 5 mg/325 mg, 21 pills. b. Resident #253; hydrocodone/ acetaminophen 5 mg/325 mg, eight pills, c. Resident #240; Zolpidem (a hypnotic) 5 mg, 28 pills. d. Resident #254; hydrocodone/ acetaminophen 5 mg/325 mg, one card with six pills and one card with 15 pills; hydrocodone/ acetaminophen 10 mg/325 mg, 23 pills; Oxycodone 10 mg one card with 21 pills and one card with 30 pills; Oxycontin 40 mg,11 pills and Diazepam (an anti-anxiety medication) 5 mg , six pills. e. Resident # 194; Tramadol 50 mg, 15 pills. f. Resident # 97; Tramadol 50 mg, six pills and lorazepam 0.5 mg, 12 pills. This deficiency substantiates Complaint Number OH 034.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** Based on record review and interview the facility failed to ensure Resident #214's blood sugar was accurately documented on the medication administration record (MAR). This affected one resident (Resident #214) of 22 residents whose medical records were reviewed. The facility census was 93. Findings include: Review of the facility Grievance Quality Assurance (QA) log revealed two entries related to concerns with medication administration involving Resident #214. An entry, dated 06/13/14 generated by the resident's family related to physician notification of blood sugar and on 05/04/14 related to concerns with medications. Both concerns revealed the nurses involved were educated and as a result of the incident on 06/13/14 a nurse was suspended. Review of a nursing progress note, completed by Registered Nurse (RN) #18, dated 06/18/14 timed 12:30 P.M. revealed Resident #214's family told the nurse on 06/13/14 Resident #214's blood sugar that morning had been 60 and the night nurse (RN #26) told the resident to drink a full glass of cranberry juice. RN #18 documented he had been told in report, by RN #26 that Resident #214's blood sugar had been low but when questioned how low, RN #26 stated the blood sugar was 80. On 08/14/14 at 7:05 P.M. interview with RN #26 verified she was the nurse assigned to administer medications to Resident #214 on 06/13/14. The RN stated she recalled checking the resident's blood sugar that morning and it was 60. The RN stated she got the resident a cranberry juice with three sugar packets and had the resident drink it. The RN stated she got called away to another resident and forgot to document the blood sugar and also did not notify the physician (the resident had an order to notify the physician if her blood sugar was less than 80). The RN stated when she was reviewing the MAR before she left for the day she realized she had not documented the resident's blood sugar and couldn't remember what it was, so she documented it was 80. The RN verified the blood sugar of 80 was not accurate and that the resident's blood sugar that morning was actually 60, which required physician notification which she failed to do. This deficiency substantiates Complaint Number OH 945.