STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455638	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenview Nursing and Rehabilitation	401 Owen LN Waco, TX 76710

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse and resulted in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with state law through established procedures for three of seven residents (Residents #1, #2 and #3) reviewed for abuse and neglect . 1. The facility failed to report Resident #1's fall on 4/15/2024, which resulted in a facial injury, in a timely manner to the State . 2. The facility failed to report resident on resident abuse with Resident #2 and Resident #3 that occurred on 4/03/2024 in a timely manner to the state. These failures could place residents at risk for abuse, neglect and a decreased quality of life. Findings include: 1. Record review of Resident #1's face sheet, dated 4/29/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Chronic Obstructive Pulmonary Disease (a condition involving constriction of the airways and difficulty breathing), Dementia (progressive memory loss), Hypertension (high blood pressure), Congestive Heart Failure (weakness in the heart that leads to a buildup of fluid in the lungs), Mood Disorder, Acute Respiratory Distress and Chronic Pain. Record review of Resident #1's Optional State Assessment MDS, dated [DATE], reflected a BIMS of fourteen (14), which indicated Resident #1 had no cognitive impairments. Resident #1's functional status for transfers, eating or toilet use was supervision. Record review of Resident #1's SBAR form, dated 4/15/2024, reflected RN A entered Resident #1's room and saw Resident #1 on the floor with two EMTs rolling Resident #1 onto a lift blanket. The SBAR reporting form indicated RN A asked the EMTs what happened, and they told her the resident fell . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/2024 at 1:52 PM, FM D stated they saw Resident #1 at theER on [DATE] and she was not responding to them. She stated the resident had a cut on her nose. FM D stated the ER Doctor told FM that the EMS crew found Resident #1 face down with blood on her face. FM D stated Resident was intubated and put in ICU but later was taken off life support on 4/22/2024 and passed away. During an interview on 4/29/2024 at 11:35 AM, CNA B stated she was working on 4/15/2024 and was walking up the hall with the EMS crew headed to Resident #1's room. She stated she saw PT C coming up the hall towards them and PT C stated Resident #1 had fallen and was face down on the floor. CNA B stated when she arrived in the room, Resident #1 was face down on the floor and was breathing slowly. She stated the EMTs patted Resident #1 and she did not respond. During an interview on 4/29/2024 at 11:47 AM, ST C stated she was working on 4/15/2024 and was in Resident #1's room providing speech therapy services to Resident #1's roommate. She stated the privacy curtain was pulled between the beds. She stated, the next thing I knew I heard a big sound on the other side of the curtain as if someone had fallen. She stated she looked around the curtain and saw Resident #1 on the floor. She stated she went out in the hall and ran down the hall hollering for a nurse. She stated when she turned the corner by the nurse's station she met the EMS crew in the hall with CNA B right behind them and she told them all Resident #1 had fallen. She stated she watched them all enter Resident #1's room. She stated she did not tell anyone else that day about the fall but the next day she told the Therapy Director what happened, and the Therapy Director went and told the DON. She stated she received training on Abuse and Neglect, and she was supposed to report to the Abuse Coordinator who was the Administrator. When asked why she didn't report it, she stated I don't know. I was pretty shaken up by the whole process, the day it happened. She further stated no one from administration went and interviewed her about the fall or asked her for a statement of what she saw and heard. During an interview on 4/29/2024 at 10:46 AM, RN A stated she was working on 4/15/2024. She stated Resident #1 looked like she was struggling to breathe so she got her a breathing treatment. She stated Resident #1 had chronic COPD and it was not uncommon for her to be short of breath. She stated after the breathing treatment, Resident #1's breathing had not improved so she had spoken to Resident #1 about going to the hospital and she refused. RN-A stated she had contacted the NP who had been in the building. She stated the NP had seen Resident #1 that morning and convinced her she needed to go to the ER because she was having trouble breathing. RN-A stated she had gone to the nurse's station to call EMS and get resident's paperwork together and had left Resident #1 in her bed. She stated resident had been alert and oriented all morning, but short of breath. EMS arrived and went to the room. RN-A stated she entered the room after EMS and saw the resident face down on the floor with EMS attempting to roll her to a lift blanket. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/2024 at 10:14 am, the NP stated she was in the facility on 4/15/2024 doing rounds and was not scheduled to see Resident #1 that day. She stated about 9:30 - 10:30 am, RN A asked her to come and check on Resident #1 who was having trouble breathing and refused to go to the hospital. The NP stated when she entered the room, Resident #1 was sitting in her wheelchair and had an oxygen mask on her face and was awake and alert. She stated she spoke to Resident #1 regarding her condition and why it was important for her to go to the hospital and Resident #1 agreed to go to ER. She stated she saw Resident #1 before, and Resident #1 had been resistant to going to the ER in the past. She stated Resident #1 had chronic breathing problems and had labored breathing even at rest or with mild exertion. She stated when she left Resident #1 she was on oxygen, alert and talking. She stated it would have been ok for RN A to leave her alone in her room to go back to the nurse's station. She stated, things can happen abruptly - hard to tell if staff had been in the room if that would have changed. During an interview on 4/29/2024 at 12:15 PM, the DON stated RN A went to her on 4/15/2024 and told her she was sending Resident #1 out to the ER; then she went back later on and told her Resident #1 was found on the floor and she thought EMS had dropped Resident #1. The Therapy Director had first come up to her the next day, 4/16/2024 and stated the ST was in the room and Resident #1 had not fallen, then a couple days later, the Therapy Director went back up and said ST was in the room and heard a noise and then saw Resident #1 on the floor. The DON stated at that point Resident #1 had already passed away in the hospital. The DON stated at that point on or about 4/22/2024, she informed the AD. She stated it would have been the AD's responsibility to report the incident to the State Agency . She stated there was no suspicion about Abuse and Neglect and nobody thought it was a situation that needed to be reported. She further stated, I was missing pieces to the story, and I didn't know I was missing pieces . During an interview on 4/29/2024 at 12:58 PM, the AD stated, I did not have any awareness that there was an unwitnessed fall. He stated there was a dispute in regard to the allegation that she was found on the floor and that is the reason why it was not reported or investigated. He stated he was responsible for reporting . Record review of the facility policy Abuse, neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, reflected: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported . 2. The administrator or the individual making the allegation immediately reports his or her suspicions to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility 2. Record review of Resident #2's face sheet, dated 04/30/2024, reflected a [AGE] year-old female admitted [DATE]. Resident #2 had diagnoses which included anxiety disorder (an emotion which is characterized by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events), Bipolar Disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows), Hypothyroidism (underactive thyroid) and Heart Failure (a condition that occurs when the heart muscle doesn't pump blood as well as it should). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2 's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 00 out of 15, which indicated severely impaired cognition. Resident #2 required assistance with activities of daily living. Record review of Resident #2's Care Plan, date initiated 01/19/2021, reflected Resident #2 had an ADL self-care performance deficit related to confusion and impaired balance. She required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. She required total assistance with bathing and limited assistance with eating. She required two-person assistance for all ADL's and one person assist for eating. Record review of Resident #2's progress notes reflected no documentation regarding an abuse allegation on 04/03/2024. Review of the miscellaneous tab reflected one nurse's note written by the DON at 2350 (11:50 PM) on 04/03/2024, which documented Resident #3 attempted to grab Resident 2's pants and when asked Resident #3 reported he was not doing anything. The residents were separated and Resident #2 was assessed to have no signs or symptoms of trauma, no redness, bruising, tearing, no signs or symptoms of physical or psychological distress. Per the note the resident did not say anything happened when she was asked. An attempt was made to contact Resident #2's RP but received no answer. The Interim administrator and regional nurse were notified of the event and assessments. No incident report was written. Record review of Resident #3's face sheet, dated 04/30/2024, reflected a [AGE] year-old male admitted [DATE]. Resident #3 had diagnoses which included Alzheimer's Disease (disease which causes the brain to shrink and brain cells to eventually die affecting a person's ability to function), Pain in left knee, Reduced mobility, Cognitive Communication Deficit, Other sexual dysfunction not due to a substance or known physiological condition. Record review of Resident #3's Quarterly MDS, dated [DATE], reflected he had a BIMS of 02 out of 15, which indicated severely impaired cognition. Resident #3 required assistance with activities of daily living. Record review of Resident #3's Care Plan dated 10/18/2022 reflected he had an ADL self-care performance deficit related to impaired mobility and impaired cognition. He required supervision for bed mobility, transfer, eating, dressing, toileting, personal hygiene, and one-person physical assist for bathing. The Care Plan reflected Resident #3 had a behavior problem related to a history of exhibiting sexually inappropriate and possessive behavior directed toward a specific female resident. It also reflected Resident #3 had impaired cognitive function/impaired thought process related to Alzheimer's and encephalopathy (disease of the brain that alters brain function or structure) . Record review of Resident #3's progress notes reflected no documentation regarding an abuse allegation on 04/03/2024. Review of the miscellaneous tab reflected one nurse's note written by the DON at 2350 (11:50 PM) on 04/03/2024 which documented Resident #3 attempted to grab Resident #2's pants and when asked Resident #3 reported he was not doing anything. The residents were separated, and Resident #3 was assessed, taken to his room, assisted with hygiene, and assisted into bed. An attempt was made to contact Resident #3's RP but received no answer. The Interim administrator and regional nurse were notified of event and assessments. No incident report was written. Interview with Resident #2 on 04/30/2024 at 11:05 AM. Resident #2 was unable to converse. The resident was sitting in a chair outside. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON at 4:55 PM on 04/30/2024 with the Administrator present reflected the DON said she received a call from the night nurse that Resident #3 attempted to grab Resident #2's pants. The DON stated she went to the facility and the night nurse told her Resident #3, was a pervert and was pulling on the pants of Resident #2 with hand motion moving up and down Resident #2's pants. It was dark and could not really see to determine what happened. There were no notes in the record from the night nurse, who was no longer employed at the facility. The DON said she completed an assessment on Resident #2 and there were no signs of redness, bruising or trauma of any kind and documented on a nurses note. She said she reported this to the administrator and regional nurse on 04/03/2024 and was advised this was not a reportable abuse incident. She stated, I did what administration said to do . Interview with the Administrator at 4:44 PM on 04/30/2024 with the DON present. The Administrator said the incident was discussed between the DON, himself and the regional nurse and they concluded the incident was not a reportable incident at the time. He reported he is the abuse coordinator and it is his responsibility to report abuse allegations to the state. He stated, looking back it probably should have been reported as abuse. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation Policy-Reporting and Investigating policy, dated Revised September 2022, reflected: Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious injury . 6. Upon receiving any allegations of abuse, neglect, exploitation misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of the residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the allegation was verified appropriate corrective action was taken for one of six residents (Resident #1) reviewed for abuse and neglect . The facility failed to report, within five days, the results of an investigation of an allegation of Abuse and Neglect involving Resident #1 when she fell on [DATE]. This failure could place residents at risk for continued abuse or neglect without appropriate corrective actions being taken. Findings include: Record review of Resident #1's face sheet, dated 4/29/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Chronic Obstructive Pulmonary Disease (a condition involving constriction of the airways and difficulty breathing), Dementia (progressive memory loss), Hypertension (high blood pressure), Congestive Heart Failure (weakness in the heart that leads to a buildup of fluid in the lungs), Mood Disorder, Acute Respiratory Distress and Chronic Pain. Record review of Resident #1's MDS, dated [DATE], reflected a BIMS of fourteen (14), which indicated Resident #1 had no cognitive impairments. Record review of Resident #1's SBAR form, dated 4/15/2024, reflected RN A entered Resident #1's room and saw Resident #1 on the floor with two EMTs rolling Resident #1 onto a lift blanket. The SBAR form indicated RN A asked the EMTs what happened, and they told her the resident fell . During an interview on 4/29/2024 at 12:15 PM, the DON stated RN A went and told her she was sending Resident #1 out to the ER then she went back later on and told her Resident #1 was found on the floor and she thought EMS had dropped Resident #1. The Therapy Director first came to her the next day, 4/16/2024, and stated the ST was in the room and Resident #1 had not fallen, then a couple days later, the Therapy Director went back and said the ST was in the room and heard a noise and then saw Resident #1 on the floor. The DON stated at that point Resident #1 had already passed away in the hospital. The DON stated at that point she informed the AD. She stated it would be the AD's responsibility to investigate. She stated there was no suspicion about Abuse and Neglect and that an investigation was not completed. She further stated, I was missing pieces to the story, and I didn't know I was missing pieces. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/2024 at 12:58 PM, the AD stated, I did not have any awareness that there was an unwitnessed fall. He stated there was a dispute in regard to the allegation that she was found on the floor and that is the reason why it was not investigated. He stated he was responsible for ensuring an investigation is done . He said these incidents should be reported to him so he can ensure residents are safe. Record review of the facility policy Abuse, neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, reflected: All reports of resident abuse (including in juries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .Investigating Allegations: 1. All allegations are thoroughly investigated. The administrator initiates investigations.