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	10/14/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 44317 Based on interviews and record review, the facility failed to ensure residents received services with reasonable accommodation of resident's needs and preferences for 1 of 1 facility reviewed for resident rights. The facility failed to ensure the phones were working consistently and receiving incoming phone calls. This failure could place residents at risk of not receiving calls from family, friends, or providers leading to anxiety, sadness, and decreased quality of life. Findings included : During a telephone interview on 10/14/24 at 10:59 AM with an anonymous FM, they stated phone calls to the facility would ring only a couple of times then disconnect. They stated they called the facility four times last week and only two of the calls were answered. They stated the intermittent problem had been going on for a couple of months. They stated the SW had provided her personal cell phone number and they had left messages on the personal cell phone. During an interview on 10/14/24 at 12:01 RN C stated she had received reports from family members that they had attempted to call the facility and their calls did not go through. She stated most of the residents had cell phones, so they received calls. During an interview on 10/14/24 at 12:12 PM with RN D, she stated there had been a problem with the phones mostly on the weekends. She stated sometimes the ringers were turned off or down and they did not know a call came in . She stated eventually they figured out the phones were not ringing and fixed the problem. Residents could have missed calls if the incoming calls went unanswered. During an interview on 10/14/24 at 2:45 PM LVN A stated she had received complaints from families about the phones not working right. She stated, per the families, the call did not go through or went straight to voice mail. She stated the administration was aware of the problem. She stated she had given her personal cell phone number to some family members. She stated if the phones were not working and a resident had gone to the hospital or an appointment, the hospital may not have been able to get through to give report for continuity of care. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/24 at 3:00 PM, the SW stated there had been intermittent issues with the phones and fax machines for a couple of months. She stated families had told her that phone calls do not always go through. She stated she had given her personal cell phone number to family members. She stated the concerns were reported to the administration. She stated having instances of incoming calls not being received could have delayed residents having contact with their loved ones causing anxiety or agitation . During an interview on 10/14/24 at 4:20 PM, the DON stated she had worked at the facility about a month. She stated she had received reports that intermittently, incoming calls did not always go through. She stated she had reported the issue to the ADM and the regional nurse. She stated the regional nurse was going to escalate the issue. She stated she reported the issue just before the ADM went on vacation on 10/07/24. She stated she expected the phone to work 24/7. She stated she was not aware of any missed calls from providers. She stated providers call the nursing on-call phone as needed. The on-call phone was a cell phone rotated between the ADONs. She stated a negative outcome for residents was disappointment of not receiving a call timely. She stated when a resident was sent to the emergency room , the nurses were to call the hospital every two hour for report or updates, rather than risk missing a call from the hospital. During an interview on 10/14/24 at 4:38 PM, the AIT stated he had been at the facility for about three weeks. He stated he heard there were occasional glitches with the calls, but the phone system was not completely down. He stated the MS had been on the phone with the phone provider earlier. He stated when calls did not go through on the first attempt, the caller could get angry or frustrated. During an interview on 10/14/24 at 4:58 PM, the MS stated the phones run off the internet, so it was harder to troubleshoot than when it was just a phone line going to the phone pole. He stated about three months ago, a phone company technician came out and reprogrammed all the phones and as far as he knew everything was working fine. He stated he had heard phones ringing and saw the receptionist transfer calls. He stated he heard today that incoming calls had not gone through all the time. He stated he just finished an hour-long phone call with the provider, and they would send out a technician . He stated if the calls did not go through, residents may miss phone calls. Review of the facility policy, Resident Rights, revised 02/2021, reflected in part, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: f. communication with and access to people and services, both inside and outside the facility; cc. access to a telephone, mail, and email; dd. Communicate in person and by mail, email, and telephone with privacy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observations, interviews, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of three residents (Resident #1 and Resident #2) reviewed for ADLs. The facility failed to ensure Resident #1 and Resident #2 received showers as scheduled. This failure could place residents at risk of a decline in hygiene, at risk for skin breakdown, loss of dignity, and decline in quality of life. Findings included: Review of Resident #1's significant change in status MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old male admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including hypertension (high blood pressure), Chron's disease (a type of inflammatory bowel disease), type 2 diabetes (a condition that affects the way the body processes blood sugar), epilepsy (a neurological disorder causing seizures), schizoaffective disorder (a mental health disorder that is marked by a combination of symptoms, such as hallucinations or delusions, and depression or mania), muscle weakness, and abnormalities of gait and mobility. Section C (Cognitive Patterns) reflected a BIMS score of 11 indicating moderately impaired cognition. Section GG (Functional Abilities) reflected he required partial/moderate assistance with bathing and transfers. Review of Resident #1's comprehensive care plan, a focus, revised on 08/29/24, reflected Resident #1 had impaired physical functioning related to debility, cognitive impairment, and fracture. Interventions reflected he required partial/moderate assistance with bathing. A focus, revised on 07/30/24 reflected Resident #1 had episodes of being resistive to care. Interventions reflected, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed upon time. Review of Resident #1's ADL Bathing Log from 09/15/24 through 10/14/24, reflected he received five showers - 09/16/24, 09/18/24, 09/23/24, 09/27/24, and 10/08/24. Review of Resident #1's progress notes from 9/01/24 through 10/13/24, reflected no documentation of bathing offered or refused. The progress notes reflected no documentation of negotiating a time for ADLs. During an observation and interview on 10/14/24 at 12:04 PM revealed Resident #1 sitting in a wheelchair in the dining room. His hair was somewhat disheveled. He stated he was going out for an appointment, so he tried to make himself look presentable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/24 at 3:46 PM, Resident #1 stated he hardly ever got showers. He stated, If I had to guess, I would say I got three showers in the last 30 days. He stated he was supposed to get showers on Mondays, Wednesdays, and Fridays. He stated the staff hardly ever offered showers. He stated there was one time when he was not feeling good, and he told the CNA he did not want a shower but only that one time. He stated it made him feel like the staff did not care about me. Review of Resident #2's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old male admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including type 2 diabetes (a condition that affects the way the body processes blood sugar), dementia, malnutrition, epilepsy (a neurological disorder causing seizures), and repeated falls. Section C (Cognitive Patterns) reflected a BIMS score of 8 indicating moderately impaired cognition. Section GG (Functional Abilities) reflected he required supervision or touching assistance for bathing. Review of Resident #2's comprehensive care plan revised on 10/14/24, reflected a focus of impaired physical functioning related to debility and cognitive impairment. The interventions reflected he required partial/moderate assistance with showering. Review of Resident #2's ADL Bathing Log from 09/15/24 through 10/13/24 reflected he received seven showers - 09/18/24, 09/23/24, 09/27/24, 09/29/24, 10/2/24, 10/8/24, and 10/12/24. The log reflected he was not available on two of his scheduled shower days - 10/05/24 and 10/10/24. Review of Resident #2's progress notes from 09/13/24 through 10/14/24, reflected no documentation that bathing was refused. During an observation and interview on 10/14/24 at 12:16 PM, Resident #2 was sitting on the edge of his bed eating his lunch. His hair and clothes were disheveled. He stated he could not remember how often he showered or if staff offered showers. During an interview on 10/14/24 at 2:27 PM, the ADON stated if a resident refused a shower or bed bath, the CNA was expected to tell the nurse. The nurse was expected to talk with the resident and provide education about the benefits of bathing. If the resident continued to refuse, the expectation was the nurse would write a progress not documenting the education provided and the refusal. She stated if a resident was in an even numbered room, bathing was scheduled for Monday, Wednesday, and Friday. If a resident was in an odd numbered room, bathing was scheduled for Tuesday, Thursday, and Saturday . She stated residents had the right to refuse. Not bathing could lead to skin issues or infection. During an interview on 10/14/24 at 2:45 PM, LVN A stated she had worked at the facility for just over a year. She stated when a resident refused a shower, she talked with the resident and encouraged them to shower. If the resident continued to refuse, she told the CNAs to document that the nurse had been notified. She stated not bathing routinely could have caused skin breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/24 at 3:40 PM, CNA B stated she had worked at the facility for a year. She stated if a resident refused a shower she talked to the resident and tried to influence and encourage them to comply. She stated she notified the charge nurse when a resident refused. CNA B opened an electronic medical record and demonstrated how the CNAs documented bathing. She stated they checked the yes box if the resident was bathed. They checked the no box if bathing was not completed. If bathing was not scheduled for the shift or the day, they could check the n/a box. She stated they just checked the boxes . She stated if bathing was not documented, residents may develop skin problems. During an interview on 10/14/24 at 4:20 PM, the DON stated she had worked at the facility for about a month. She stated it was her expectation that bathing was completed as scheduled either Monday, Wednesday, Friday or Tuesday, Thursday, Saturday. She stated if a resident refused bathing, the CNA notified the nurse and the nurse talked with the resident. If the resident continued to refuse, the nurse was expected to write a progress note. She stated she had recently given an in-service that went over this information. She stated not bathing routinely could have caused poor hygiene, odor, or infections. She stated at this time, no-one that she was aware of monitored routine documentation. During an interview on 10/14/24 at 4:31 PM, the ADON described the process of how the CNAs documented showers. She stated CNAs checked the appropriate box but did not type any free text because it was not in their scope. She stated the nurses were expected to write a progress note when bathing was refused. During an interview on 10/14/24 at 4:38 PM, the AIT stated it was his expectation that documentation was completed timely and accurately. He stated if bathing was not completed routinely, a resident may have experienced infections or wounds. During an interview on 10/14/24 at 4:55 PM, the DON stated Resident #2 had been out of the facility for several days recently which may have accounted for some showers not being documented. She stated she did not find any progress notes for either Resident #1 or Resident #2 for refusal of bathing. Review of the facility Census Report printed 10/14/24, reflected Resident #1 was staying in a room ending with an even number. The report reflected Resident #2 was staying in a room ending with an odd number. Record review of an in-service conducted on 10/02/24 and again on 10/04/24 by the DON, reflected staff were educated on Bed Bath versus Shower, Shower Schedule, and Refusals. 19 staff signed as attending including LVN A and CNA B. Review of the policy Activities of Daily Living (ADLs), Supporting, revised 03/2018, reflected in part, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care). Review of the policy Bath, Shower/Tub, revised 02/2018, reflected in part, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the shower/tub bath.