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	05/17/2025

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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 8 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1's call light was within reach on 05/16/2025. This failure could place residents at risk of their needs not being met. Findings include: Record review of Resident #1's admission record, dated 05/16/2025, reflected a [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #1 had diagnoses which included: acute on chronic systolic (congestive) heart failure (a sudden worsening of existing heart failure), type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye (central part of the retina, swells from the leaking fluid and causes blurred vision), muscle weakness (lack of physical or muscle strength), cognitive communication deficit (trouble with thinking and using language), legal blindness (severely limited vision). Record review of Resident #1's Quarterly MDS assessment, dated 03/25/2025, reflected the resident had a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 was dependent in the areas: toileting hygiene, lower body dressing, putting on/taking off footwear and personal hygiene. Resident #1 required substantial/maximal assistance in the area: shower/bathe self. Record review of Resident #1's care plan, dated 05/16/2025, reflected Resident #1 was care planned for fall r/t unaware of safety need, vision problems and had an intervention of call light within reach at all times. During an observation on 05/16/2025 at 10:45 am., Resident #1 was observed in his wheelchair while his call light was observed hanging over his nightstand approximately 2 feet away from Resident #1's wheelchair. (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 - Few	During an interview and observation on 05/16/2025 at 2:37 pm., Resident #1 stated that he was not aware his call light was hanging over his nightstand due to him being legally blind. Resident #1 stated that staff never clip his call light to him. Resident #1 stated if he needed assistance, he would have to wheel himself in the hallway or wait until a staff member comes to his room. Resident #1 was observed in his wheelchair while his call light was observed hanging over his nightstand approximately 2 feet away from Resident #1's wheelchair. During an interview with CNA A on 05/16/2025 at 2:50 pm., CNA A stated she and CNA B both were working the north hall where Resident #1 resided. CNA A stated CNAs made rounds every two hours or as needed. CNA A stated it was everyone's responsibility to ensure residents' call lights were within reach. CNA A stated, when making rounds, CNAs checked to see if residents needed assistance and ensured the residents were safe. CNA A stated the purpose of a call light was for a resident to call for assistance. CNA A stated she was not aware Resident #1's call light was not within reach. CNA A stated if a resident could not reach the call light, the resident would not be able to call for help if they need something. During an interview with CNA B on 05/16/2025 at 3:00 pm., CNA B stated she and CNA A both worked the north hall where Resident #1 resided. CNA B stated CNAs made rounds at least every two hours unless there was a resident who may require more frequent checks. CNA B stated that it was the CNAs and anyone who entered the resident's room to ensure the call light was in reach. CNA B stated during rounds, CNAs were taught to ensure the resident call lights were in reach. CNA B stated she was not aware Resident #1's call light was not within reach. CNA B stated if a resident's call light was not in reach the resident would not be able to call for assistance. During an interview with the DON on 05/16/2025 at 3:45 pm., the DON stated all residents' call lights should be always within reach. The DON stated it was everyone's responsibility to ensure residents' call lights were always within reach. The DON stated if a resident's call light was not within reach the resident would not be able to receive assistance if they needed it. During an interview with the ADM on 05/16/2025 at 4:35pm., the ADM stated call lights should always be within reach. The ADM stated it was the nursing staffs' responsibility to ensure call lights were within reach. The ADM stated if a resident call light was not within reach, then the resident may not be able to call for assistance. The ADM stated her expectation was for all resident's call lights to always be within reach. A record review of the facility's Call Lights: Accessibility and Timely Response policy, dated 2024, reflected The purpose of this procedure is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow resident to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 2. All residents will be educated on how to call for help by using the resident call system. 3. Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Staff will ensure the call light is within reach of resident and secured, as needed