

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Greenview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable, and a resident with pressure ulcers received necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for one 1 (Resident #3) of six residents reviewed for quality of care.</p> <p>The facility failed to complete weekly skin assessments, obtain wound care orders and a therapy consult for Resident #3, causing his wound to deteriorate.</p> <p>These failures placed the resident at risk of not receiving adequate care and services, pain, and decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #3's face sheet dated 5/29/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Spastic Quadriplegic Cerebral Palsy (congenital disorder of movement, muscle tone or posture), other mixed anxiety disorders, urine retention, chronic pain, Hypertension (high blood pressure) and cramps and spasm.</p> <p>Review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 13 suggesting resident was cognitively intact. Further review of MDS, section M, Skin Conditions reflected a clinical assessment was completed to determine risk of pressure ulcer/injury and that Resident #3 was at risk of developing pressure ulcers/injuries. The MDS, Section M, reflected Resident #3 did not have any pressure ulcers/injuries at that time.</p> <p>Review of Resident orders from 4/1/2025 until 5/29/2025 reflected no treatment orders for wound care or medications for wound healing.</p> <p>Review of Resident #3's progress notes dated 4/28/2025 at 11:30 pm revealed Resident c/o burning sensation to abrasion on right calf. Redness to abrasion noted on assessment. This nurse cleaned 5x5x0.1cm abrasion to back of right calf with normal saline and applied TAO and a dry dressing.</p> <p>Review of Resident #3's progress notes dated 4/29/2025 at 11:55 pm reflected F/U skin injury. This nurse cleaned 5x5x0.1cm abrasion to back of right calf with normal saline and applied TAO and a dry dressing. On assessment this nurse noted slight redness on border of skin injury. No c/o of increased pain/discomfort.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's progress notes dated 5/2/2025 to 5/28/2025 reflected no notes about wound on right rear calf and no notes about therapy consult .</p> <p>Review of Resident #3's progress notes dated 5/29/2025 at 1:08 pm by LVN-A reflected Partial thickness wound with etiology of trauma to right posterior superior calf. 80% granulation tissue noted and 20% slough. Dried serous drainage noted to peri wound. Peri wound with no abnormality noted. New wound care order of Partial thickness wound with etiology of trauma to right posterior superior calf. Cleanse with wound cleanser or normal saline. Pat dry. Apply TAO to wound bed. Apply calcium alginate. Cover with silicone border dressing to promote autolytic debridement daily and PRN. RP, [name] notified of area and of new wound treatment. RP also verbalized consent for resident to be seen by [name] Wound care. No concerns or questions voiced at this time.</p> <p>Review of Resident #3's weekly skin assessments revealed he received a skin assessment on 4/10/2025 and not again until 5/29/2025.</p> <p>During an interview on 5/29/2025 at 11:04 am, Resident #3 stated he had had the wound on the back of his calf for a couple weeks. He stated they were cleaning it and putting some stuff on it but hadn't done that in while. He stated the wound was from the back of his calf rubbing on his wheelchair because of the way his lower leg hangs. He stated one of the staff gave him a towel to sit on to cover the edge of the wheelchair seat but it was still rubbing and hurt. He stated a nurse told him to leave it open so it would heal, but it kept rubbing on his chair and had gotten worse. He stated a staff person also told him they would have therapy look at his chair to see if they could help. He said he supposedly had a custom wheelchair on order but did not know the status on that. Resident #3 stated the wound was burning but the pain medications he was already on helped some.</p> <p>During an interview on 5/29/2025 at 11:15 am, LVN A said she had just started as wound care nurse and was not sure how long the facility was without a wound care nurse before she started. She stated she would be reaching out to the wound care doctor for orders and follow up for Resident #3. LVN A stated she checked the EMR and the last weekly skin assessment was completed on 4/10/2025 for Resident #3.</p> <p>During an observation conducted with LVN-A present, on 5/29/2025 at 11:04 am, Resident #3 was noted to have a wound approximately (investigator did not have a ruler to measure but wound care nurse took measurements afterwards) 1cm wide by 2cm long on his right rear calf. The wound area was oval, red around the edges, open and not covered. The top layer of the skin had been rubbed away exposing raw skin. Observation also revealed that Resident #3 was sitting on a towel that was draped over the front edge of his wheelchair seat.</p> <p>During an interview on 5/29/2025 at 9:43 am, WCMD stated he had taken over wound care of this facility about 5 weeks ago. He stated when he first started coming the facility had 13-14 wounds and now they were down to 5-6. He stated he has observed residents being offloaded using wedges or other cushions and heels being floated and wounds were improving and healing.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/30/2025 at 5:12 pm, DON stated skin assessments are supposed to be completed weekly. She stated they had a problem back in April where the skin assessments were not being generated as expected in the electronic medical records, but the nurses still knew to complete the skin assessments and chart in the progress notes. DON stated the prior wound care nurse was responsible for making sure the skin assessments were being done, but she had been terminated. She stated the facility had just hired a new wound care nurse, but the charge nurses were responsible for completing weekly skin assessments in the interim, until the wound care nurse had been replaced.</p> <p>Review of undated facility policy skin Assessment reflected:</p> <p>It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment.</p> <p>1.</p> <p>A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury.</p> <p>7.</p> <p>Documentation of skin assessment:</p> <p>a.</p> <p>Include date and time of the assessment, your name, and position title.</p> <p>b.</p> <p>Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.).</p> <p>c.</p> <p>Document type of wound.</p> <p>d.</p> <p>Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain).</p> <p>e.</p> <p>Document if resident refused assessment and why.</p> <p>f.</p> <p>Document other information as indicated or appropriate.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 3 residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure there was appropriate supervision on [DATE] when Resident #1, who resided on the secure unit, exited the secure unit, after RN A left the unit (to respond to a code after not being familiar with the CPR policy), and then one of the facility's side exits and got into the passenger seat of a parked fire truck in the parking lot.</p> <p>An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:28pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures placed residents at risk of elopement, falls, or injuries and not having their end-of-life wishes followed.</p> <p>Findings included:</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected he was an [AGE] year-old-male who was admitted to the facility on [DATE] with diagnoses including dementia (memory loss), major depressive disorder with severe psychotic symptoms (loss of contact with reality) (extreme sadness), anxiety (extreme worry), unsteadiness on feet, and frontotemporal neurocognitive disorder (when nerve cells in the brain are lost). Section E - Behavior, revealed that he had physical and verbal behavior directed toward others in the last 1-3 days, and wandering had occurred in the last 4-6 days in the last week. His BIMS score was a 9, indicating he was moderately cognitively impaired.</p> <p>Review of Resident #1's elopement risk assessment dated [DATE] revealed a score of 6, which indicated he was a high risk of elopement.</p> <p>Review of Resident #1's care plan dated [DATE] revealed that he was to reside in the secure unit due to risk of elopement and to have elopement risk assessments per facility protocol.</p> <p>Review of progress note dated [DATE] at 10:00am by RN A reflected, Patient was brought back to unit by staff up front. Stated he was seen at the front door. Patient came back very calm and was even pushing another patient with him. Patient stated, I was just wanting to look at the fire truck. He was unable to state how he exited. All areas were checked. Side and back door are locked. All windows are secured shut and unable to open. Management informed and looked at cameras and noted he went out secure main door when it did not secure properly behind me as I was exiting to respond to a code on the other side of the building. DON contacted family. Patient was put on 1:1 (monitoring where a staff member is directly responsible for one resident) And q15 minute checks was started also immediately. Reminded all staff to ensure door is locked when going out.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of progress note dated [DATE] at 10:00am by the DON reflected, at 0939, this nurse received a phone call from charge nurse {RN A}, stating that this resident was found at the front door of facility during a time of a code on another resident on one side of the building, and an emergency on the other. {RN A} verbally stated as he was exiting the doors of the secure unit to go assist, he stated that, the resident must have followed me out of the secure unit and that is how he ended up in the mix of the facility due to the nature of the emergency and situation. Admissions coordinator was at the front of the building and seen resident as he was at the front door of the building holding his remote and was with the EMS staff and firemen and immediately redirected resident back to the secure unit. Resident was approachable and easily willing to go back to the secure unit. He pushed another resident in his wheelchair to the south station of the building, in good spirits, hugging everyone and, glad to be a help to others. No injuries were reported on resident. This nurse instructed charge nurse, {RN A} to immediately initiate one on one monitoring on this resident to indefinite timing, 24 hours a day, as resident is a high elopement risk with good understanding verbalized. {The DON} instructed {RN A} to ensure that anytime the secure doors are opened by any staff member or at any time, that they need to make sure they are completely closed and locked to where no resident in a secure unit can exit. There are two other doors on secure unit that have been tested and do work; alarms will sound and go off if they are pushed.</p> <p>This nurse spoke with daughter, and explained to her the situation and she thanked nurse for the phone call and update and stated she was at a funeral and wouldn't be back up to the facility for the rest of the day. This nurse and {daughter} discussed this residents' disease process, and she expressed her feelings about it and how she is sad seeing the rapid decline in her father, cognitively, and she and her brother are coming to realization to acceptance about it. She stated that resident used to be a Life support educator, and that in his mind, he probably really did think he was a part of the emergency he seen happening and followed the nurse/EMS staff, thinking he was helping save someone's life. I informed {daughter} that I had re-initiated one on one monitoring on her dad due to safety measures, and it would be a 24-hour monitoring, and she tearfully expressed her appreciation. I told her to contact this nurse at any time with any questions, concerns, or needs and she verbalized understanding.</p> <p>In an attempted interview on [DATE] at 9:10am with Resident #1, the HHSC surveyor attempted to ask him about recent events, but he stated he did not remember the events in question.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:16am with RN A he stated that on [DATE] he was the RN assigned to the secure unit and was assisted by CNA B. He was aware that CNA B was off the unit for lunch at the time a code (indicating a resident had stopped breathing and needed CPR) was called, but he thought it was just him and 1 other nurse working in the building during that time, so he said he had to respond to the code. He stated that he was only off the unit for a couple of minutes. He stated that when he left the unit the door did not lock behind him and that the door got stuck unless it was pushed shut. He stated that a code was never called over the loudspeaker, and he had heard through word of mouth from another CNA there was a code. When he arrived to the code, the RN told him the resident collapsed, so she started CPR and never had a chance to call the code. He stated they (EMS/Nurse) were already working on the resident and didn't need any help, so he went back to the secure unit. He stated he knew his CNA was off the unit and he knew he was leaving the residents unattended/unsupervised. His stated his priority was the emergency when he found out about it. He could not recall who told him about the code. He stated that he received no notification other than CNA word of mouth. He stated that based on experience as a nurse he was to respond to all codes, and he had no direction from the facility on responding to codes. He stated he did not see Resident #1 was by the doors when he went off the unit and didn't know he was followed. He stated he had received no training on CPR response teams and no training on the team or identifying who responded or not.</p> <p>During an interview on [DATE] at 11:36am with the DON she stated that she was not aware CNA B was off the unit when RN A responded to the code. She thought there was an additional agency staff present on the secure unit that day. She later confirmed there was no agency staff present on the secure unit on [DATE] and just RN A and CNA B were working on the secure unit. She stated 2 other nurses were working on the other side of the building and there was no reason for RN A to leave the secure unit.</p> <p>During an interview on [DATE] at 1:19pm with the AC, she stated that RN A never attended the code. She also stated that she was at the front door of the facility when Resident #1 had made his way to the door, and that she had redirected him back to the secured unit. She was unable to verify if Resident #1 had made it outside the front door or just to the front door of the building.</p> <p>During an interview on [DATE] at 3:22pm with the RNC he stated that if a code happened on a certain hall, the staff that worked that hall should respond, and that all direct care staff were CPR trained and certified.</p> <p>During an interview on [DATE] at 6:30pm with RN A, he stated that based on experience as a nurse he was to respond to all codes, and he had no direction from the facility on responding to codes. He stated he had received no training on CPR response teams and no training on the team or identifying who responds or not. He stated that for that incident there was no code called over the loudspeaker, he was just notified through CNA word of mouth.</p> <p>During an interview on [DATE] at 8:36am with MA C, she stated that she did not recall any recent in-services on elopement or resident supervision.</p> <p>During an interview on [DATE] at 8:43 am with RN B, she stated they had not received in-serving on elopement since the incident on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with the MD on [DATE] at 10:30am she stated that her expectation for staffing in the secure unit was that there would be somebody working in the unit to make sure residents could not harm themselves or others, to provide medications and help during meals. For staffing, she stated that there were times when the residents were stable, and the environment varied based on the patients' behaviors. She said if they were poorly staffed or things happened, more staff could be needed, but in general somebody needed to be always back there with the residents. She stated she had concerns if all staff left the secure unit for an extended amount of time, but if someone was stepping out to get help or something quick, that should be allowed. In the situation on [DATE] she stated that RN A was a very well-trained nurse, and she thought it was appropriate that he stepped out to check on things and then returned. She stated that a resident would be ordered to live on the secure unit due to Alzheimer's disease, not being aware of his surroundings, and not being aware of potentially dangerous situations. The MD stated she had no more concerns with Resident #1 getting around the fire truck than any other residents. She stated she did not think Resident #1 had the capacity to drive, pick up heavy things, or move equipment anymore. The MD stated there was potential for injury, but she didn't know that the fire truck would sit much higher than the bed in his room or a table in the secure unit, so the MD did not know that it would be more of a fall risk. She stated it wouldn't be good if Resident #1 got into any hoses and the MD did not know if Resident #1 had any strength to pull heavy equipment.</p> <p>In an interview with the RNC on [DATE] at 11:17am he stated that the facility did not have any policies specific to the secure unit.</p> <p>In an interview on [DATE] at 12:20 pm with the DON, she stated that every staff member had a code legend on their badge, and that if there was a resident coding, someone would get on the loudspeaker/intercom and call a code blue, which would alert everybody, so staff could respond. She stated they did not designate teams; the nurses would just respond. The expectation of responding nurses would be that they call 911 and get crash cart to help out.</p> <p>In an interview with MA C on [DATE] at 12:31pm she stated that she was working on the south hall on [DATE] as a medication aide. She stated that the south side entrance door alarm went off (meaning that the exit door had been opened) so she responded to the door. She looked outside and did not see any residents outside. She stated she was able to see out into the driveway where the fire truck was parked. She stated that she thought the door alarm may have been triggered by the in and out of the emergency personnel on the other side of the building, and that the emergency personnel took the coded resident out of the facility's main front door. She stated she worked until 2:00pm on [DATE] and was never informed of Resident #1's elopement, and that she did not receive in-service for elopement until [DATE], even though she had worked another shift on [DATE]. She stated that a negative outcome of a resident leaving out of the south door unsupervised was that they could potentially walk into traffic, get lost, get injured, or die.</p> <p>Review of video footage provided by the facility revealed RN A leaving the secure unit on [DATE] at 9:22:37am and returning at 9:24:18am. Resident #1 could be seen on camera peeking out from his bedroom door and watching RN A leave the unit, and then Resident #1 ambulated to the secure unit door and pushed it open at 9:22:42 and began walking down the south hallway. Resident #1 was then seen through a different camera view, pushing open and walking out of the building's south side entrance and walking into the driveway and ambulating into the passenger side of the fire truck with its lights on, that was parked there. There were no facility staff or emergency personnel in view of the camera.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a different camera view of the facility outside the front main entrance revealed Resident #1 approaching the ambulance that was parked in the driveway in front of the main entrance. Resident #1 was seen observing the ambulance but did not open any of the doors, and no facility staff or emergency personnel were in view of the camera. Resident #1 was observed making his way to the facility front door on his own.</p> <p>In a different camera view of the facility inside the main entrance at 9:25:27 the AC can be seen making her way from the entrance, down the hallway toward the dining area at 9:25:57., At this time her back was toward the main entrance, and she went out of the camera's view until she reappeared at 9:28:01 and began her way back toward the front entrance doors. At 9:28:40 she came back into the camera view and was observed guiding Resident #1 down the hallway with their hands intertwined. Resident #1 was returned to the secure unit at 9:30:52am.</p> <p>Review of the facility's Safety and Supervision of Residents policy dated 2018 revealed, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified needs and identified hazards in the environment.</p> <p>Review of the facility's policy titled 'Emergency Procedure - Cardiopulmonary Resuscitation' last revised February 2028 reflected, Select and identify a CPR Team for each shift in the case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue effort and directing other team members during the rescue effort.</p> <p>The ADM, DON, and RNC were notified on [DATE] at 4:18pm that an Immediate Jeopardy had been identified due to the above failure and an IJ template was provided.</p> <p>The following POR was accepted on [DATE] at 11:43am:</p> <p>On [DATE] an abbreviated survey was initiated at the facility. On 5-30-25 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate Jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure there was appropriate supervision on [DATE] when Resident #1, who resides on the secure unit, exited the secure unit, after RN A left the unit, and then one of the facility's side exits (approximately 160 feet from the secure unit) and got into the passenger seat of a parked fire truck (approximately an additional 220 feet from the exit door) in the parking lot.</p> <p>Immediate Jeopardy Plan of Removal - F689 (Supervision to Prevent Accidents)</p> <p>1. Resident #1 (Affected Resident):</p> <p>Resident #1 was safely returned to the secure unit by the medication aide on [DATE] after exiting the unit unsupervised. The elopement was self-reported to HHSC on [DATE] by the Administrator. Immediate actions taken included:</p> <p>o Initiation of 1:1 supervision by the CNA on 5-24-25 for 24 hours from the time of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>o The charge nurse updated the elopement risk assessment on 5-25-25, reviewed and updated the care plan as needed.</p> <p>o The interdisciplinary team review was initiated by the Administrator and the interdisciplinary team on 5-25-25.</p> <p>o CNA B and RN A were instructed on 5-24-25 by the DON to not leave residents unattended, especially those on secure unit, even for a moment.</p> <p>o Door hardware on the secure unit was repaired by the maintenance director to ensure door latched when closing and signage placed (Please make sure the door is closed and latched behind you!) on 5-26-25. All staff were in-serviced by the DON/designee on 5-30-25 to ensure that the door is closed and latches when exiting. New hire employees will be in serviced during orientation and prior to the start of their first shift. PRN employees and agency staff will be in-serviced prior to the start of their next assigned shift.</p> <p>2. Identification of At-Risk Residents (Facility-Wide Review):</p> <p>On [DATE], the MDS coordinator initiated a full audit of all the residents on the secure unit to identify additional elopement risks. All current elopement risk assessments were reviewed and updated as needed on 5-30-25 by the MDS coordinator. Care plans were reviewed by the MDS coordinator on 5-30-25 to ensure they reflect current interventions. All staff were in-serviced by the DON/designee on 5-30-25 to immediately notify administration by phone of any breaks or coverage issues. Door alarm systems and locking mechanisms for all exit doors were checked by maintenance on 5-26-25 and documented on a log and will be reviewed by the administrator daily.</p> <p>3. System Correction:</p> <p>o The DON/designee in-serviced all staff on elopement protocol, and supervision protocols, on [DATE] and are ongoing until all staff have completed training on 5-31-25. Mandatory in-services will be completed on 5-31-25 with all current and oncoming staff</p> <p>prior to the start of shift worked. The regional nurse provided education to the director of nursing and the administrator on 5-30-25 regarding supervision protocols, elopement prevention, and response expectations for secure unit. Agency staff and PRN staff will not be assigned to the secure unit unless they have completed the facility's elopement prevention and supervision in-service. This will be verified through the human resources and staffing coordinator prior to working their shift. This will be validated by the DON/designee.</p> <p>o A revised policy on code response was implemented by the regional nurse on [DATE] to require designated responders to any emergency or code being called, ensuring secure unit staff do not leave residents unattended.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>o Daily door audits were implemented on 5-30-25 by the maintenance director for all secure unit exits for 14 days and then weekly thereafter. This will be documented by the maintenance director on a daily audit form and reported to the Administrator daily.</p> <p>o The DON/designee in-serviced staff on 5-30-25 when assigned to the secure unit staff are now required to formally sign out when taking a break or leaving the unit to verify designated coverage is in place prior to leaving the unit ensuring continuous supervision of residents in accordance with facility protocols. Agency staff and PRN staff will not be assigned to the secure unit unless they have completed the facility's elopement prevention and supervision in-service. This will be verified through the human resources and staffing coordinator. This will be validated by the DON/designee.</p> <p>o Each staff member attending the in-service will complete a verbal return demonstration to confirm comprehension of the content presented, and once the staff verbalizes understanding by repeating back the information then the in-service will be signed at that time.</p> <p>o Verbal return demonstrations will include scenario-based questions, policy clarification, and role-specific expectations (e.g., code response protocol, secure unit coverage requirements).</p> <p>o Competency will be assessed in real time by a licensed nurse, department manager, or clinical educator.</p> <p>o Staff who do not successfully complete the verbal return demonstration will receive immediate re-education and follow-up assessment to ensure understanding.</p> <p>4. Administrative Oversight/Monitoring:</p> <p>oThe DON/designee is completing daily visual checks on secure unit supervision and door status for 14 days starting [DATE].</p> <p>o The Maintenance Director will check the secure unit door latch and magnetic locking mechanism daily starting 5-30-25 for 14 days, then weekly thereafter, to ensure the door closes and secures properly. If there is a malfunction to the door the maintenance will fix it and if unable the location will be monitored directly by designated staff member until repaired.</p> <p>o QAA Committee will review supervision compliance and elopement documentation monthly for 3 months. ADHOC QAPI meeting was held on 5-30-25 by the Administrator and IDT team to review the deficiency and the process of when the POR will be completed.</p> <p>5. Completion Date:</p> <p>[DATE]</p> <p>The surveyor monitored the POR on [DATE], [DATE], and [DATE] as follows:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During observation on [DATE] between 9:00am-9:50am revealed the south side entrance door working properly, it had a delayed egress mechanism, signage that stated Emergency Exit Only Push Until Alarm Sounds. Door Can Be Opened in 15 Seconds. When tested, the door did not immediately open, and after 15 seconds a loud alarm sounded and the door opened to the outside. An exit door in the secure unit revealed a sign that read Do not use door. An alarm code was used by facility staff to enter/exit the secure unit main entrance as well as the back exit door, the back exit door also had a delayed egress mechanism and sounded a loud alarm when opened without the door code.</p> <p>During an observation on [DATE] at 9:47am revealed signage placed on secure unit doors advising staff to ensure door closure and latching. The surveyor tested the secure unit door to ensure its latching.</p> <p>Review of Resident #1's progress note dated [DATE] reflected, One on one monitoring, indefinite timing, 24 hours a day, on this resident continues due to resident being a high elopement risk. Resident sitting up in bed. Resident attempting to wake up roommate and easily redirected back to bed. Resident alert and oriented to self.</p> <p>Review of Resident #1's elopement risk assessment dated [DATE] revealed he was scored at a 13, indicating high risk for wandering. Review of secure unit resident list revealed 2 additional residents whose elopement risk assessments were updated on [DATE] and the other 13 were done prior to [DATE].</p> <p>Review of Resident #1's care plan updated [DATE] reflected he was a high risk for elopement, was to maintain 1:1 supervision until behavior stabilized and IDT determined it was safe to discontinue.</p> <p>Review of a document titled Systemic Issues No real-time staff assignment to monitor unit during dual emergencies revealed the regional nurse provided education on the following topics, 1:1 supervision maintained, door security protocol re-education completed with staff on secure unit, mock drill to assess emergency-response door security codes, secure unit alarms re-tested and validated, resident's care plan and elopement risk assessment updated, QAPI follow-up scheduled in 30 days for reassessment and was signed by the DON, ADM and the RNC.</p> <p>Review of 15 residents who resided on the secure unit revealed updated elopement risk assessments and care plans with assessment and/or updated dates of [DATE].</p> <p>Review of a log titled Daily Secure Doors Door Monitoring Log reflected dates of:</p> <p>[DATE]-10am Checked Door Functions</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's QAPI meeting agenda, dated [DATE], titled Unauthorized Exit from Secured Memory Care Unit revealed the MD, MS, MDS, DOR, ADON, DON, RNC, and ADM were all in attendance.</p> <p>Review of the facility's in-service dated [DATE] and [DATE], and conducted by the RNC, ADON, and DON titled Elopement Prevention and Supervision In-Service Packet revealed all staff (CNA B, MA C, and RN A's signatures were visible) were in-serviced on the following:</p> <ol style="list-style-type: none"> 1. Supervision Protocols for Residents on Secure Units <ul style="list-style-type: none"> -Never leave residents on a secure unit unsupervised. -Ensure coverage is confirmed before leaving for any reason. -Document any staff hand-offs. -Notify supervisor immediately if understaffed. 2. Elopement Prevention Strategies <ul style="list-style-type: none"> -Know which residents are at risk (review care plans and risk assessments). -Ensure resident doors and alarms are operational at the beginning of each shift. -Report and document any unsafe conditions immediately. 3. Door Security and Exit Door Monitoring <ul style="list-style-type: none"> -Check that doors latch and alarms sound properly at the start and end of each shift. -Ensure signage remains visible on all secure exits. -Never prop open doors to the secure unit. -Report door malfunctions to maintenance immediately. 4. Code Response Expectations and Designated Response Team Procedures <ul style="list-style-type: none"> - Secure unit staff must not respond to codes unless alternate staff has assumed coverage. -Follow the designated code response team assignments. -If you're not assigned to respond, remain at your post. -Call for assistance if help is needed, but do not leave residents unattended. 5. Reporting and Documentation of Coverage Breaks <ul style="list-style-type: none"> -Notify supervisor or nurse manager prior to leaving your post for break or emergency. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Ensure a staff handoff is documented.</p> <p>-Use the assignment sheet or staff coverage log.</p> <p>-Report and document any observed lapses in supervision.</p> <p>Review of 2 sign out sheets titled Secure Unit Staff Break Sign Out revealed 1 sheet dated [DATE] with 3 staff members clock in times and clock out times handwritten. A sheet dated [DATE] with 5 staff members clock in times and clock out times handwritten.</p> <p>Review of in-servicing post tests in employee files in the HR office reflected staff completed question/answer tests to verify their comprehension of the in-services provided with dates observed of 5/30 and 6/1.</p> <p>Review of a log titled Daily Administrative Oversight Log reflected columns titled Observer (DON/Designee), Supervision in place on secure unit? (Yes/No), Any gaps in coverage (yes/no), Door functional and locked? (Yes/No), Corrective actions taken if issues found. The logs had dates of [DATE]-[DATE] with yes and no answers and the ADON's signatures next to each date.</p> <p>Review of the revised CPR Policy dated [DATE] reflected, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance with these rights, the facility will implement guidelines regarding cardiopulmonary resuscitation (CPR) in accordance with accepted clinical standards and federal regulations.</p> <p>Emergency Preparedness and Code Response (Added [DATE])</p> <p>- A revised Code Response Protocol was implemented by the Regional Nurse on [DATE] to ensure resident safety during emergency situations.</p> <p>- Designated emergency responders will be pre-identified for each shift and are responsible for responding to codes and medical emergencies.</p> <p>- Staff assigned to the secure unit are prohibited from leaving the unit unattended under any circumstance, including to respond to a code, unless relieved by appropriate coverage.</p> <p>- This measure ensures continuous supervision of high-risk residents and aligns with regulatory requirements under F689 (Supervision to Prevent Accidents) and F678 (CPR).</p> <p>- Staff have been educated and a log of designated code responders is maintained at each nurse's station for reference.</p> <p>Review of handwritten staff unit assignments dated 6/12 and 6/13 revealed a CR next to 2 nurses per shift indicating they were the code responders for their shift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:47am with the MS, he stated that he was notified of the elopement on [DATE] and went to the facility at 10am that day to begin door checks on all facility doors to ensure latching/security. He stated that he was to be responsible for secure unit door checks for 2 weeks from [DATE], and then weekly. He stated the protocol was to check the doors behind him and ensure proper latching/locking.</p> <p>During an interview on [DATE] at 5:24pm with CNA C, she stated that she was providing 1:1 supervision to Resident #1 due to his elopement that occurred on [DATE]. She stated that she received in-service training on elopement, door safety and security, supervision instructions specific to Resident #1, and keeping the door code private.</p> <p>During interviews on [DATE] from 5:13pm-5:40pm with 1 MA, 4 CNA's, 1 LVN, and 1 SC from multiple shifts revealed they were all in-serviced between [DATE]-[DATE] on elopement, ensuring door safety/security, visual checks if doors alarm, supervision of residents, keeping door codes private, not leaving residents alone in the secure unit, and who the abuse coordinator is. They stated they were to immediately go to the door that alarmed to see who exited, and ensure they see the person that exited before leaving the door to ensure it was not a resident.</p> <p>During an interview on [DATE] at 10:47am with the MS, he stated that he repaired the secure unit doors so they would close without rubbing on [DATE]. He also stated that he adjusted the timing on the doors so they have 3 seconds, from the time the code is input on the keypad, meaning whoever is trying to gain entry, would have 3 seconds to open the door after inputting the code on the keypad, and if they don't open it within the 3 seconds it would re-engage the magnetic lock. He confirmed he conducts daily audits of all secured exit doors and turns them into the ADM.</p> <p>During an interview on [DATE] at 11:25am with the MDSC she stated that she was given instructions to update/view all care plans and ensure elopement risk assessments were completed. She stated that the secure unit RN completed the elopement risk assessments, but she verified all assessments were done on [DATE]. She also went into each care plan and made sure they all had problem/focus areas for elopement risk.</p> <p>During an interview on [DATE] at 11:37am with RN A he stated he got in-serviced after the elopement on needing to make sure there was always staff on the secure unit. He stated that during his shifts he made sure all doors were working properly and alarms were working, if they were not, he was to notify the DON or the ADM immediately. He stated that Resident #1 was still residing at the facility and on 1:1 monitoring. He stated he had not had any issues with the secured unit door not closing or latching. He stated if a code were called or something else happened, he was to stay on the unit. If there was a code, he was to page the code and start CPR. He confirmed he had to take a posttest to confirm his comprehension of the topics presented.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #2) of two residents reviewed for medication pass, in that:</p> <p>The facility failed to ensure Resident #2 was administered his medications within the one hour before and one hour after timeframe.</p> <p>These failures placed residents at risk for not receiving therapeutic effect of their medications as ordered by the physician.</p> <p>Findings included:</p> <p>Review of Resident #2's face sheet dated 6/1/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Parkinson's Disease (central nervous system disorder), Type 2 Diabetes (blood sugar regulation disorder), Asthma (breathing disorder), Hypertension (high blood pressure), major depressive disorder and Epilepsy (seizure disorder).</p> <p>Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 13 suggesting no cognitive impairment.</p> <p>Review of Resident #2's orders dated 6/1/2025 reflected a physician's order for Ryтары Oral Capsule Extended Release 48.75-195 MG (Carbidopa-Levodopa) Give 4 capsule by mouth three times a day related to PARKINSON'S DISEASE WITHOUT DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS.</p> <p>Review of Resident #2's MAR audit for the last 14 days reflected the following late administrations:</p> <p>Ryтары Oral Capsule Extended Release 48.75-195 MG (Carbidopa-Levodopa)</p> <p>Scheduled on 05/21/2025 at 06:00 am</p> <p>Administered on 05/21/2025 09:49 am (2 hours and 49 minutes late)</p> <p>Ryтары Oral Capsule Extended Release 48.75-195 MG (Carbidopa-Levodopa):</p> <p>Scheduled on 05/23/2025 at 06:00</p> <p>Administered on 05/23/2025 at 09:33 (2 hours 33 minutes late)</p> <p>Ryтары Oral Capsule Extended Release 48.75-195 MG</p> <p>Scheduled on 05/27/2025 at 06:00 am</p> <p>Administered on 05/27/2025 at 08:32 am (one hour and 32 minutes late)</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Rytary Oral Capsule Extended Release 48.75-195 MG (Carbidopa-Levodopa)</p> <p>Scheduled on 05/20/2025 at 22:00 (10 pm)</p> <p>Administered on 05/21/2025 at 02:52 am (3 hours and 52 minutes late)</p> <p>Rytary Oral Capsule Extended Release 48.75-195 MG (Carbidopa-Levodopa)</p> <p>Scheduled on 05/21/2025 at 22:00 (10 pm)</p> <p>Administered on 05/22/2025 01:18 am (2 hours and 18 minutes late)</p> <p>Rytary Oral Capsule Extended Release 48.75-195 MG (Carbidopa-Levodopa)</p> <p>Scheduled on 05/22/2025 at 22:00 (10 pm)</p> <p>Administered on 05/23/2025 04:25 am (5 hours and 25 minutes late)</p> <p>Review of Resident #2's care plan reflected the following problems: [Resident #2] has the potential for complications r/t Parkinson's with an intervention: Administer [Resident #2's] medications as ordered.</p> <p>During an interview on 6/1/2025 at 1:57 pm, Resident #2 stated his medications had often been late. He stated when his Parkinson's medications had been late, it had caused him to have increased tremors in his hand and made it hard for him to hold or grasp things without dropping them or spilling them. He stated it had further affected his speech when they had been late as his speech had started to slur. He stated it had usually been the first dose of the day and the last dose of the day that had been late, and staff had often woken him late after midnight to give him his meds scheduled for 10 pm. Resident #2 stated the doctor had told him his medications for Parkinson's were very time-oriented and needed to be on a schedule to help him with his symptoms.</p> <p>During an interview on 5/30/2025 at 5:29 pm, the DON stated medications were to be administered within one hour before or after the scheduled time. She stated they had a lot of agency nurses, and these nurses would not accept shifts if they must pass meds. She stated medications being late had been a problem since she started in March 2025, but they were doing the best that they could. She stated she was aware of medications being late on the north side due to the use of agency nurses who were not familiar with the residents, and it took them longer to pass meds. She stated nurses and medication aides were to chart in the EMR when the med was given so the administration time reflected the time the medication was given.</p> <p>During an interview on 6/1/2025 at 2:40 pm, the DON stated it was her expectation that medications be given on time and that staff arrive on time and give meds on time. The DON stated her concerns with Resident #2's late medications for Parkinson's disease were adverse effects which were usually an increase in symptoms including tremors. She stated this could be uncomfortable for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/1/2025 at 3:36 pm, the MD stated she had heard from residents and staff, as well, about late medications. She stated she was aware they had been working on it to improve, but consistent staffing had been a problem. She stated with Parkinson medications they need to be given within a few hours but within the one-hour time frame would be ideal. She stated in general - except in an emergency - within an hour would be ideal for med administration. She said her concerns for Resident #2 were that there was a sufficient gap between doses to help manage symptoms. She stated she was not aware of what the gaps in doses had been for Resident #2 and she would have to look into it.</p> <p>Review of facility policy Administering Medications dated Q3 , 2018 reflected the following:</p> <p>Medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>Medications must be administered in accordance with the orders, including any required time frame.</p> <p>Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for the facility's one of one kitchen reviewed for physical environment.</p> <p>The facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior in the facility's only kitchen.</p> <p>These failures could affect residents by placing them at risk of contaminated food due to the lack of a well-kept kitchen environment.</p> <p>Findings included:</p> <p>In an observation on 05/29/2025 at 8:57am of the entryway to the facility's only kitchen there was a large dead squashed cockroach on the tile floor, with visible shoe print marks around it. Underneath a storage rack in the kitchen was another large dead cockroach surrounded by food debris, and stained floor tiles. Inside an uncovered dirty floor drain beneath a kitchen prep sink were 4 large dead cockroaches. To the right side of the ice machine were 2 large dead cockroaches surrounded by debris and a singular leaf and to the left of the ice machine was 1 large dead cockroach surrounded by other debris and stains.</p> <p>In an interview with the DS on 5/29/2025 at 9:00am she revealed that the dead bugs in the kitchen were water bugs, and she stated the pest control guy should have been coming out to the facility any day. She said she was shorthanded in the kitchen and if she could get some extra help that's when it would get more thoroughly cleaned. She stated that every night the floors got mopped, and once a month the floors got buffed.</p> <p>In an interview with the MS on 5/29/2025 at 10:00am he stated that the bugs in the kitchen were American cockroaches (waterbugs) and that he did not know anything about the kitchen being short staffed. He stated that they did have a pest control contract and when pest control visited the facility, the chemical they used would kill those bugs, and help make them not reproduce. He stated the bugs came in through the doors and drains. If it was hot outside, they wanted to be inside where it was cool, and around the water. He stated it was the kitchen staff's responsibility to sweep and mop the floors daily. He stated he thought there was a grate over the drain.</p> <p>In an additional observation on 05/29/2025 at 12:09pm of the facility's only kitchen the American roaches were cleaned out of the drain under the prep sink, but there were still roaches behind the ice machine, under the storage racks, and in the entryway to the kitchen.</p> <p>In an interview with the DON on 05/30/2025 at 4:04pm she revealed that she was not aware of the American cockroaches in the kitchen. The dietitian asked her to do a walk-through of the kitchen last week. She did not see them that day. She knew they have frequent pest people going there. She stated she had 2 baby roaches go in her office through a vent on the wall a couple weeks ago. When shown the pictures of the cockroaches in the kitchen, she stated it did not appear the floor was mopped every night. She stated that when she left late at night sometimes around 7pm, the trays would still be waiting to be washed outside the kitchen door.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Greenview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the ADM on 05/30/2025 at 5:05pm he stated that he had gone through the kitchen before and saw one or two of the American cockroaches but did not see a lot of them. He mainly saw them near drains. He stated that if kitchen staff saw the bugs, they should be immediately removed and they should not just wait for pest control to go to the facility. He said the kitchen staff were responsible for ensuring the cleanliness of the kitchen. He stated that the kitchen floors should be swept and mopped twice daily, once after breakfast, and once after dinner, and swept after all three meals. He stated that they did not keep a log of when the floors were swept/mopped in the kitchen. He stated that a negative outcome of large bugs being in the kitchen was that remnants of those bugs could potentially get into residents' food.</p> <p>Review of the facility's Sanitation policy dated last revised October 2008 reflected, the food service area shall be maintained in a clean and sanitary manner.</p> <p>All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections when 1 of 5 staff (CNA A) observed for infection control failed to perform proper hand hygiene.</p> <p>CNA-A failed to perform hand hygiene while serving and assisting residents with their meal in the facility's only dining room on 5/29/2025.</p> <p>These deficient practices placed residents at risk for cross contamination and spread of infection.</p> <p>Findings included:</p> <p>During an observation in the dining room on 5/29/2025 at 12:31 pm CNA-A was observed three separate times, carrying meal trays from the kitchen cart and taking them to the residents. He then placed the tray on the table and assisted residents by setting up their trays - taking utensils and unwrapping them from the napkin and placing them on the tray, and opening drinks. CNA-A carried meal trays to residents without using hand hygiene in between the carrying/passing each tray.</p> <p>During an interview on 5/29/2025 at 12:42 pm, CNA-A stated he had passed four trays to residents without using hand hygiene in between. He stated he had received training on performing hand hygiene between each tray passed. CNA-A stated he did not have a reason for passing trays without hand hygiene, that it was not acceptable and that he knew what he was supposed to be doing. CNA-A stated passing trays without performing hand hygiene could lead to cross contamination with bacteria or germs and residents could get sick especially older people.</p> <p>During an interview on 5/30/2025 at 4:44 pm, the DON stated she was aware of staff passing trays during lunch in the dining room without performing hand hygiene. She stated her expectation was that staff will sanitize their hands before passing trays and in between passing trays. She stated her concerns would be for cross contamination and infections. She stated they have residents at risk for infection and a worst-case scenario could be a resident gets an infection and becomes septic [[life threatening complication of an infection]. She stated she has done in services on hand hygiene with staff and she expected them to follow training.</p> <p>During an interview on 5/29/2025 at 5:01 pm, the ADM stated his expectation was that staff will perform hand hygiene after each time they touch or pass a tray. They can either wash their hands or use hand sanitizer. The ADM stated his concerns for staff not performing hand hygiene would be that germs can be passed easily, the facility had a population that could get sick easily and infection like the common cold, flu or viral or bacterial infections could be spread.</p> <p>Review of Facility Policy Handwashing/Hand Hygiene dated Q3 , 2018, reflected: This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>1.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.</p> <p>2.</p> <p>All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>7.</p> <p>Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:</p> <p>a.</p> <p>Before and after coming on duty.</p> <p>b.</p> <p>Before and after direct contact with residents.</p> <p>o.</p> <p>Before and after eating or handling food.</p> <p>p.</p> <p>Before and after assisting a resident with meals</p>