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	07/03/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure the residents had the right to be free from physical abuse and neglect for 3 (Resident #1, Resident #2, and Resident #3) of 9 residents reviewed for abuse and neglect. 1. The facility failed to provide continuous one to one monitoring for Resident #1 after repeated targeted aggressive behavior against Resident #2. An Immediate Jeopardy (IJ) situation was identified on 07/01/25 at 6:55 pm for failure #1. While the IJ was removed on 07/02/25 a 6:42 pm the facility remained out of compliance at a scope of isolated that with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. 2. The facility failed to ensure Resident #3 was not physically abused by MA F on 06/25/2025 when MA F grabbed Resident #3's wrist. These failures could affect the residents by placing them in mental anguish or emotional distress, pain, and physical harm. Findings included: 1.Resident #1 Review of Resident #1's face sheet dated 07/01/25 reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including other frontotemporal neurocognitive disorder (degeneration of the frontal and temporal lobes of the brain, leading to a range of behavioral, language, and movement difficulties) vascular dementia (a decline in thinking skills caused by conditions that reduce or block blood flow to the brain, leading to brain damage), with other behavioral disturbance, and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly interfere with daily life). Review of Resident #1's quarterly MDS assessment, dated 05/23/25, reflected a BIMS score of 9, indicating moderate cognitive impairment Section E Behavior reflected physical behavior directed towards others (example hitting, kicking, pushing, scratching, grabbing, abusing others sexually) – behavior of this type occurred every 1 – 3 days. Verbal behaviors directed towards others (example threatening others, screaming at other, cursing at others) – behavior of this type occurred every 1 – 3 days. Review of Resident #1's care plan reflected focus – noted behaviors of physical aggression: 1. 05/13/15 resident to resident – Resident #1 was seen holding a fork/spoon like object and was on the verge of trying to stab another resident (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. 05/19/25 resident to resident - Resident #1 grazed the other resident in the back of head with remote 3. 05/28/25 resident to resident – Resident #1 hit another resident with a broom while sitting in the secure dining room 4. 06/01/25 resident was destroying dining room area by overturning table and chair Review of Resident #1's care plan reflected interventions for noted behaviors of physical aggression: 1. 05/13/25 document behaviors in the clinical record. 2. 05/13/25 let physician know if behaviors are interfering with daily living. 3. 05/13/25 refer to psychologist/psychiatrist as needed. Review of Resident #1's care plan reflected focus revised on 05/29/25 indicated Resident #1 had potential to demonstrate verbally abusive behaviors related to vascular dementia, with other behavioral disturbance. Review of Resident #1's care plan reflected focus revised on 05/26/25 indicated Resident #1 resided on the facility secured unit related to deemed at risk for elopement. Review of Resident #1's care plan reflected focus revised on 06/30/25 indicated Resident #1 demonstrated behavior symptoms/risk at times such as cursing at other residents who are in the way and following other resident (Resident #2) around telling him to get out from his property. Review of Resident #1's care plan reflected focus revised on 05/26/25 indicated Resident #1 was at risk for behaviors related to demonstrates physically abusive behaviors 05/26/25 – resident to resident, Resident #1 ambulating on hallway with staff member when he hit another resident in the face. Review of Resident #1's care plan reflected interventions dated 05/26/25 indicated psychiatric referral as needed to evaluate and follow in house or outpatient. Observation of the facility secured unit on 07/01/25 at 12:10 p.m., revealed Resident #1 was sitting quietly at a dining table. Residents had finished eating. Two staff members were observed in the dining area performing normal work duties. Observation in facility secured unit on 07/01/25 at 2:56 p.m., Resident #1 reflected the door was closed to Resident #1’s room. When surveyor entered with the assistance of RN D, Resident #1 was sitting on his bed. His roommate was laying in his own bed sleeping. Observed no 1:1 monitoring of Resident #1. Review of Resident #1’s Nurses Note dated 05/09/25 written by the ADON reflected Resident #1 was placed on the secure unit due to elopement risk. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1’s Nurses Note dated 05/13/25 written by LPN A reflected aide (name of aide not stated) reported to LPN A that Resident #1, who was the roommate of Resident #2, was seen holding a fork/spoon like object and was on the verge of trying to [stab] Resident #2. The aide was unable to remove the fork/spoon out of Resident #1’s hands. LPN A was called and able to remove the fork/spoon from Resident #1. Both residents were assessed for injury, none at the time will continue to monitor both residents for any complications. Review of Resident #1’s Nurses Note dated 05/20/25 written by RN C reflected Resident #1 was holding a remote in hand and refused to put remote down. Resident #1 picked up broom in the dining room hallway and attempted to hit another Resident #2. CNA (name of CNA not stated) able to redirect and remove broom from Resident #1. Resident #1 was holding remote that he refused to put down. Resident #1 “grazed” Resident #2 in the back of the head with remote. Residents separated for safety. Resident #1 closely monitored post incident. Review of Resident #1’s Progress Note Psychiatric Initial Evaluation dated 05/20/25 by PNP reflected dementia with behavioral disturbances. Patient #1 currently on 1:1 observation, continue current medication regimen. Continue to assess for adverse effects and let medication management associates know. Patient has significant cognitive impairment consistent with Alzheimer’s disease (a progressive neurodegenerative disorder that gradually destroys memory and thinking skills, eventually impacting the ability to carry out even the simplest tasks). Patient with history of becoming easily agitated. Staff report patient was physically aggressive towards another resident with difficulty redirecting over the weekend. No aggressive behaviors noted during evaluation. Seen for initial psychiatric evaluation by request of facility. Consider sending to psychiatric hospital or emergency room if patient is a danger to self or others. Review of Resident #1’s Nurses Note dated 05/20/25 written by RN D reflected PNP saw Resident #1. PNP said she hoped the medications will help calm him down and he will have less behaviors. Review of Resident #1’s Nurses Note dated 05/26/25 written by LVN E reflected Resident #1 walked down the hallway of the secured unit when he hit Resident #2 on the face. Both Resident #1 and Resident #2 grabbed each other’s arms. Residents separated by two staff members (names of staff members no listed). No acute injuries noted. Resident #1 was easily redirected and was calm after being separated from Resident #2. Will continue to monitor. Review of Resident #1 Psychiatry Follow Up from PNP dated 05/27/25 reflected Resident #1 was involved in an altercation with another resident over the weekend, where he was the aggressor. Resident #1 with vascular dementia with behavioral disturbances, currently 1:1 (indicates that one staff member is assigned to continuously observe a single patient. This was often necessary for patients with certain behavioral conditions). Consider sending to emergency room or psychiatric hospital. Dementia in other diseases classified elsewhere, moderate with other behavioral disturbance – Resident #1 with history of becoming easily agitated. Was involved in an altercation with another resident [Resident #2] over the weekend. Resident #1 was the aggressor. Resident #1 continued to be on 1:1, required close monitoring. He appeared to dislike one particular resident (Resident #2). Resident #1 seen in room on 1:1 observation, did not engage much, oriented to self only, significant cognitive impairment consistent with dementia. Resident #1 required 1:1 observation and required close monitoring. Staff were to monitor, redirect, and ensure Resident #1’s safety. It was recommended to keep Resident #1 and Resident #2 in separate locations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #2 Review of Resident #2’s face sheet dated 07/01/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including senile degeneration of brain (decline in cognitive abilities, memory, and behavior associated with old age), Major depressive disorder, wandering in diseases (repetitive, aimless movement from place to place, often without a clear purpose or destination, especially in individuals with dementia or other cognitive impairments). Review of Resident #2's quarterly MDS assessment, dated 04/18/25, reflected a BIMS score of 3, indicating severe cognitive impairment. Review of Resident #2's care plan reflected focus revised on 04/12/25, indicated Resident #2 had a behavior problem related to taking other residents’ food off their tray during meals. Review of Resident #2’s Nurses Note dated 05/13/25 written by LPN A reflected Resident #1, who was a roommate with Resident #2, was seen holding a folk/spoon like object and was on the verge of trying to stab Resident #2. The aide (name of aide not stated) tried to get the folk out of Resident #1’s hands but Resident #1 was unable to give up the folk. LPN A was called to the scene and was able to remove the folk from Resident #1. Both residents were assessing for any injury, no injuries. Review of Resident #2’s Nurses Note dated 05/26/25 written by LVN E reflected Resident #2’s was walking down the hallway when he was hit on left side of jaw by another resident (Resident #1). Both residents grabbed each other's arms. Resident separated from the other resident by staff x2. No visible injuries noted. Attempted to initiate neurological assessment and vitals, Resident #2 refused at this time. Will continue to monitor. Review of Resident #2’s Nurses Note dated 05/20/25 written by RN C reflected Resident #2 was sitting in chair in dining room. Another resident (Resident #1) attempted to hit Resident #2 with broom and hit the chair. Resident #2 remained seated in dining room chair. Resident #1 grazed Resident #2’s hair on the back of the head with the remote. Resident #2 remained seated, no signs of agitation or aggressive behavior noted. Residents separated for safety. Review of Resident #2’s Progress Note Psychiatric Follow Up Evaluation dated 05/20/25 by PNP reflected Resident #2 was involved in an altercation where he was hit by another resident (Resident #1). Plan was to redirect and keep him safe. Review of Resident #2 Progress Note from PNP dated 05/27/25 reflected Resident #2 was involved in an altercation where another resident (Resident #1) hit him; Resident #2 did not retaliate. Resident #1 required redirection and safety measures. Staff were advised to try to keep Resident #2 and Resident #1 in different locations to prevent further incidents. Review of facility complaint incident report dated 06/01/25 revealed Resident #1 had a problem with Resident #2. Resident #1 is fixated on Resident #2. Resident #1 said, “he thinks resident two broke his family up.” (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Psychiatry Follow Up from PNP dated 06/10/25 reflected Resident #1 with history of becoming easily agitated and continued to be 1:1 observation, required close monitoring. On and off agitation and aggressive behavior towards one particular resident (Resident #2). Social support – Resident #1 received 1:1 observation and required close monitoring due to aggressive behavior. Follow up – staff to monitor, re-direct and keep safe, continue 1:1 observation due to behavioral issues. Keep Resident #1 and Resident #1 at different locations was encouraged. Continue secure unit placement. Consider sending to the emergency room if identified harm to self or other. Review of Resident #2’s Nurses Note dated 06/17/25 written by RN D revealed Resident #2 would take food when he walked by. Review of IDT (team is composed of various healthcare professionals who collaborate to provide comprehensive care and support for residents) meeting note dated 06/19/25 and attended by the Administrator, ADON, MDS Coordinator and therapy reflected, “Team decided that with information that we reviewed [Resident #1] would be OK off 1:1 monitoring.” No MD or PNP listed as attending meeting and no documentation of information reviewed. Review of Resident #2’s Nurses Note dated 06/20/25 written by RN D revealed Resident #2 seen walking around eating and stealing food from others. Was able to redirect him but he kept walking towards other and grabbing at food or drinks. Other patients are very upset and stating they might hit him if he kept doing it. Review of Resident #2’s Nurses Note dated 06/21/25 written by RN D revealed was going in other rooms and standing over patients while sleeping. Other patients getting upset. Review of Resident #2’s Nurses Note dated 06/26/25 written by RN D revealed continues to take other's food at times. Review of Resident #2’s Progress Note dated 07/02/25 written by MD reflected Resident #2 was the target of another resident’s (Resident #1’s) erratic behavior on 06/28/25, though staff prevented altercation. Interview on 07/01/25 at 2:42 p.m., with the PNP revealed Resident #1 was a safety concern because he was aggressive. She was concerned about his safety and the safety of the other residents if Resident #1 was not provided 1:1 monitoring. She said he was on the correct medications and if he was not given 1:1 monitoring, the facility needed to find alternative placement for Resident #1. Interview on 07/01/25 at 12:10 p.m., with RN D revealed Resident #1 “targets” Resident #2, but Resident #1 instigates things by taking food and items from residents’ trays (including Resident #1’s tray). RN D said he was not concerned Resident #1 would harm other residents and Resident #1 was currently not 1:1. RN D felt they had enough staff and Resident #1 could be watched. He said some incidents between Resident #1 and Resident #2 have occurred in the past even when Resident #1 was on 1:1 monitoring because staff was not watching. An example was when Resident #1 attempted to hit Resident #2 with a broom. Interview on 07/01/25 at 2:56 p.m., with RN D revealed Resident #1 said he was taken off 1:1 monitoring last Wednesday (06/25/25) and when RN D came to work on the following Thursday (06/26/25), Resident #1 was off 1:1 monitoring and had been off 1:1 monitoring since. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/02/25 at 11:29 p.m., CNA G revealed she had not witnessed any physical aggression towards Resident #2 by Resident #1. She said Resident #2 would go around Resident #1’s food tray and take things from his tray. CNA G example gave the example of when Resident #2 took Resident #1’s food cover. CNA G said this would aggravate Resident #1 and said Resident #1 would say something to the affect that Resident #2 was messing with his wife. Resident #1 thought that Resident #2 was in Resident #1’s home. She said Resident #1 would threaten Resident #2 when Resident #2 moved things around and said, “I’m going to kick your ass.” CNA G did not think that 1:1 monitoring was necessary because there were 2 aides in the secured unit she said when staff was there they could re-direct Resident #1. She said that Resident #1 listened to her, but she was not sure if he listened to the staff on other shifts. Interview on 07/02 25 at 2:50 p.m., LVN E revealed she had worked in the secured unit and was familiar with the relationship between Resident #1 and Resident #2. She said that Resident #1 seemed like he would get agitated when he saw Resident #2. She said Resident #1 would get upset and start walking towards Resident #2 getting verbally aggressive and cursing. She said there was an altercation between Resident #1 and Resident #2 with a broom when she was on duty, but she did not see what happened. She said a CNA got in between the residents. She said she was not concerned about resident safety because Resident #1 always received 1:1 monitoring when she was working the secured unit. She said as long as Resident #1 was 1:1 she was not concerned about safety. She said it was the responsibility of the DON and Administrator to decide if a resident received 1:1 monitoring. She said the negative effect of a resident who does not have 1:1 monitoring and needs 1:1 monitoring was that a resident could get hurt. Interview on 07/02/25 at 2:17 p.m., RN C revealed she used to work in the secured unit at night and was familiar with Resident #1 and Resident #2. She said they are physically independent in that they are not in wheelchairs and are able to walk. She said Resident #1 and Resident #2 do not like each other. Resident #1 would say, “it is my house.” She said the residents should be separated. She said Resident #1 should definitely be monitored 1:1. She said if Resident #1 was not monitored 1:1, Resident #2 can get close to him and that irritated Resident #1. She said if Resident #1 is monitored 1:1, he can be re-directed quickly. She said when he received 1:1 monitoring, he was fine but as soon as he was taken off his behaviors go back to what they were previously. She thinks that Resident #1’s behavior could cause harm to Resident #2 or himself if Resident #1 did not receive 1:1 monitoring. Interview on 07/02/25 at 12:46 p.m., with the DON revealed she had not witnessed any disturbances between Resident #1 and Resident #2, but it was reported to her by the overnight nurse (could not remember the name of the nurse) by phone that Resident #1 attempted to hit Resident #2 with a broom. The ADON had heard that Resident #1 thinks that Resident #2 was trying to “break up his family.” She said that Resident #1 found Resident #2 sitting on Resident #1’s bed and Resident #2 had an incontinent episode and Resident #1 had been “fixated” on Resident #2 since this episode. The ADON said the IDT team decided if a resident was going to come off 1:1 monitoring. She said the IDT team consists of the Administrator, the DON, Social Worker, and psychologist. She said she felt like the PNP should have been included in the decision whether to remove Resident #1 from 1:1 monitoring. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/01/25 at 5:13 p.m., CNR #1 revealed Resident #1 was fixated on Resident #2 and they were both in the secured unit, so it was not like you could keep them separate. She said the facility held an IDT meeting on 06/19/25 and the team reviewed Resident #1’s behaviors and progress note charting and found 1:1 monitoring for Resident #1 was not warranted any longer. She said the facility needed to make sure the provider was consulted and updated. She said if the PNP said Resident #1 needed to have 1:1 monitoring, then Resident #1 needed to be on 1:1 monitoring. She said if you don’t get the approval from the provider, the PNP, you run the risk of more resident-to-resident altercations. Interview on 07/02/25 at 3:15 p.m., CNR #2 revealed that during the IDT meeting on 06/19/25 that concluded that was okay to end Resident #1’s 1:1 a critical component that was missing because the PNP was not included and consulted. He said it was the responsibility of the Administrator make sure that all relevant people are present during an IDT meeting. He said the possible negative outcome of not including the PNP provider at the IDT meeting to provide input regarding the possibility of removing Resident #1 from 1:1 monitoring would be continuing issues with resident-to-resident altercations. Interview on 07/02/25 at 3:06 p.m., the Administrator revealed the PNP should have been kept in the loop when the IDT team made the decision on 06/19/25 to removed Resident #1 from 1:1 monitoring. He said he thought Resident #1 was doing better because Resident #1 did not have any incidents of altercations with Resident #1. He said that the IDT meeting participants should have included a mental health provider to discuss Resident #1’s 1:1 status. He said that Resident #1’s 1:1 monitoring should have remained intact, and he should not have been removed from 1:1 monitoring. He said the negative affect of not having a resident on 1:1 monitoring who should be on 1:1 monitoring would be that it could be unsafe for residents. The Administrator said it was his understanding that Resident #1 only had problems with Resident #2, and Resident #1 was focused on Resident #2. Resident #1 thought that Resident #2 stole his family. He also heard that Resident #2 had an incontinent incident on Resident #1’s bed and Resident #1 had not forgotten about the incident and Resident #1 was still upset about it. The Administrator said the facility was working on getting Resident #1 transferred to another facility because of his fixation on Resident #2 and concerns for Resident #1’s safety and other safety of the other residents in the secured unit. It is the responsibility of the Administrator and the IDT team to make sure that the physical and mental providers are included in the IDT meeting when making decisions about 1:1 monitoring status. Review of facility policy Resident to Resident Altercations dated December 2016 reflected the facility staff will monitor residents for aggressive/inappropriate behavior towards other residents. Occurrences of such incidents shall be promptly reported to the nurse supervisor, director of nursing services, and the administrator. If two residents are involved in an altercation staff will notify each resident's attending physician of the incident, review the events with the nursing supervisor, director of nursing and possible measures to try to prevent additional incidents, make any necessary changes to the care plan approaches to any or all of the involved individuals, document in the resident’s clinical record all interventions and their effectiveness, contract psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for interventions and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team. If after carefully evaluating the situation, it is determined that care cannot be readily given within the facility to transfer the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This was determined to be an Immediate Jeopardy (IJ) on 07/01/25 at 5:27 pm. The Administrator was notified at 6:55 p.m. The ADM was provided with the IJ template on 07/01/25 at 6:55 p.m. The following Plan of Removal submitted by the facility was accepted on 07/02/25 at 1:01 p.m. PLAN OF REMOVAL On 07/01/2025 an abbreviated survey was initiated at the facility. On 07/01/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to continuously monitor Resident #1 1:1 for multiple altercations of aggressive behavior targeted against Resident #2. IMMEDIATE JEOPARDY PLAN OF REMOVAL for F600 – Failure to Protect Residents from Abuse Tag Number: F600 Regulation: The resident has the right to be free from abuse. Deficient Practice: The facility failed to ensure that Resident #1 was continuously monitored as ordered for 1:1 supervision following multiple episodes of physical aggression toward Resident #2, placing Resident #2 at risk for harm. 1. Corrective action(s) taken for resident(s) found to be affected: Who: The Administrator/Designee and Secure Unit Charge Nurse. What: Immediately reinstated 1:1 monitoring for Resident #1 to ensure Resident #1 and Resident #2 are separated. 1:1 monitoring to include direct 24-hour eyes on supervision by dedicated/assigned staff member. In-service education provided clarification to staff to ensure Resident #1 is not left alone at any time and the protocol for providing breaks and adequate replacement for assigned staff member. When: Initiated on 07/01/2025, following incident review. Where: On the secured memory care unit, where both residents reside. Additionally: Resident #2 was assessed by the ADON/Designee for injury and psychosocial impact—no acute injury found, no acute psychosocial impact. Referral was made to [MD] on 07/01/25 to conduct follow up visit on 7/2/2025. No other residents identified during review of R-to-R altercations with Resident #1 Psychiatric Nurse Practitioner (NP) re-evaluated Resident #1 on 07/01/2025, recommending need to reinstate 1:1 due to continued aggression. The interdisciplinary team (IDT) met on 07/01/2025 and updated Resident #1’s care plan to reflect behavior management strategies, permanent 1:1 status, and physical separation plan from Resident #2 through direct 1:1 supervision. Finding alternate placement. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. How the facility will identify other residents who could be affected: Who: ADON/Designee. What: Conducted a review of all residents on the secured unit with active or recent aggressive behavior or R-to-R altercations within the last 30 days. Facility wide incidents were reviewed and are currently ongoing starting on 7/1/25 When: Audit began 07/01/2025 and will be completed by 07/02/25. Where: Secured unit. The audit includes: Review of behavior monitoring orders. Validation of 1:1 interventions being documented and implemented. Documentation is assigned to the Charge Nurse on the MAR/TAR every shift and paper monitoring, which includes location, behavior/activity and supervising staff initials, is ongoing with 1 hour frequency. Confirmation of care plan updates for any additionally identified resident and interdisciplinary review of any behavior incidents in the last 30 days. 3. Systemic changes made to ensure the deficient practice does not recur: Who: Staff Development Nurse, in coordination with Administrator/Designee and Regional Nurse Consultant. What: Regional Nurse provided education to the Assistant Director of Nursing and Administrator on 07/01/2025 by in-service education. Assistant Director of Nursing and Administrator will conduct Facility-wide in-service education and posttest for all licensed nurses, CNAs, agency and direct care staff prior to the start of assigned shift. New staff will receive training during orientation: Abuse prevention Resident to Resident altercation policy Requirements for initiating, documenting, and discontinuing 1:1 supervision. In-service provided clarification to staff outlining the expectations of 1:1 supervision, including, 24-hour eyes on supervision; not leaving Resident unsupervised at any time; providing adequate coverage of assigned staff member. Importance of timely IDT reviews and documentation in the MAR/TAR and care plan. When: Initiated on 07/01/2025 and completed by 07/02/2025 with all current and oncoming staff/agency prior to start of shift worked; new staff will receive this training during orientation. Where: In-person training held in facility and documented with sign-in sheets. (continued on next page)

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	07/03/2025

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Additional changes: Continue 1:1 Supervision Monitoring Log, to be maintained at the point of care (resident’s room or nearby nurse station), requiring hourly initials by assigned staff. Verification of completion of monitoring log will be done by ADON/designee daily. 1:1 supervision will be reviewed by IDT within 24 hours of initiation and will be reviewed daily for continued appropriateness of 1:1. 4. How the facility will monitor to ensure compliance and prevent recurrence: Who: Administrator/designee. What: Weekly audits of 100% of residents with 1:1 orders for compliance with documentation, monitoring logs, and MAR/TAR entries. Monthly reviews of incident reports involving R-to-R contact, focusing on behavioral care planning and response follow-through. When: Weekly audits for 8 weeks starting 07/02/25, followed by monthly audits for 4 months. Where: Monitoring will occur facility wide for any identified R-to-R altercations. Audit results will be reported to the QAPI Committee monthly, and immediate corrective action will be taken for any missed 1:1 interventions or breakdowns in IDT communication. 5. Date of completion: All corrective actions and training will be fully implemented by: July 02, 2025 Monitoring: Review of Resident #1’s MAR and TAR reflected 1:1 supervision continuous 24hr monitoring with every hour checks every hour for physical behaviors every shift documented every hour with no behavioral issues reflected. Observation 07/02/25 at 11:25 a.m. of Resident #1 with 1:1 monitoring dedicated/assigned staff member. Observation 07/02/25 at 1:00 p.m. of Resident #1 with 1:1 monitoring dedicated/assigned staff member. Observation on 07/03/25 at 11:40 am of Resident #1 with 1:1 monitoring dedicated/assigned staff member. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/02/25 with CRN #1 stated she assessed Resident #2 for any psychosocial impact and no acute injury found. Review of PNP documentation dated 07/01/25 re-evaluation of Resident #1 recommended need to reinstate 1:1 monitoring due to continued aggression. Review of interdisciplinary team (IDT) meeting document dated 07/01/2025 and review of updated Resident #1&rsqu[TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure that residents received routine and emergency drugs and biologicals for 1 of 6 residents (Resident #3) reviewed for pharmacy services. The facility failed to give Resident #3 her Rivaroxaban 20mg (a medication used to prevent blood clots) tablet scheduled medication on 06/22/2025, 06/23/2025, 06/24/2025 and 06/25/2025. These failures placed residents at risk not receiving the therapeutic benefit or adverse reactions to prescribed medications. Record review of Resident #3's admission record, dated 07/02/2025, reflected a [AGE] year-old female originally admitted to the facility on [DATE] and last readmitted on [DATE]. Resident #3 had diagnoses that included Type 2 Diabetes Mellitus (a condition that affects how the body uses sugar as a fuel), Senile Degeneration of Brain (a decline in an individual's memory, behavior, and cognitive abilities), Chronic Systolic Heart Failure (an impairment in the heart's ability to fill with and pump blood), Cerebral Infarction (a blood clot blockage that impair blood flow through the brain artery), Chronic Kidney Disease (an impairment in the kidney's ability to filter out toxins), Anxiety Disorder (intense and excessive worry and fear in response to real or perceived threats), Essential Hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (a chronic lung disease that limits airflow and causes ongoing respiratory symptoms), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Paroxysmal Atrial Fibrillation (an abnormal heart rhythm that is characterized by rapid and irregular beating of the upper portions of the heart). Record review of Resident #3's comprehensive MDS, dated [DATE], reflected a BIMS score of 13 which indicated her cognition was intact. Record review of Resident #3's care plan, dated 10/14/2019 and last revised 04/26/2025, reflected Focus: [Resident #3] receives anticoagulant therapy r/t Disease process of chronic embolisms (a long-term conditions that blocks blood flow), atrial fibrillation, cardiac pacemaker (an implantable device that regulates heart rate when triggered). Interventions included: Administer ANTICOAGULANT medications as ordered by physician. Observe for side effects and effectiveness Q-SHIFT. Record review of Resident #3's care plan, dated 04/13/2021 and last revised 04/26/2025, reflected Focus: [Resident #3] has chronic deep vein thrombosis (a long-term condition characterized by blood clots in the veins) BLE. Interventions included: Give medications as ordered. Observe/document for side effects and effectiveness. Record review of Resident #3's care plan, dated 05/09/2022 and last revised 04/26/2025, reflected Focus: [Resident #3] had a cerebral vascular accident (a condition in which poor blood flow to a part of the brain causes cell death). Interventions included: Give medications as ordered by the physician. Observe/document side effects and effectiveness. Record review of Resident #3's Rivaroxaban order dated 10/10/2022 revealed Rivaroxaban Tablet 20 MG Give 1 tablet by mouth in the evening for Heart valve condition give with the evening meals. Record review of Resident #3's Medication Administration Record (MAR) for Rivaroxaban reflected the medication was scheduled to be given with the evening meal. The MAR reflected that staff did not give the resident the Rivaroxaban on the following dates:06/22/2025 showed not given,06/23/2025 marked as given (Interview with MA H revealed medication was not available and was not given),06/24/2025 marked as given (Interview with MA H revealed medication was not available and was not given), and06/25/2025 showed not given. Record review of Resident #3's Medication Administration Record nurses' notes reflected the following:06/22/2025 19:38 (07:38 PM) Note Text: Rivaroxaban Tablet 20 MG Give 1 tablet by mouth in the evening for Heart valve condition give with the evening meals on oredr [spelling?].06/25/2025 17:23 (05:23 PM) Note Text: Rivaroxaban Tablet 20 MG Give 1 tablet by mouth in the evening for Heart valve condition give with the evening meals reorder. Record review of Drug Record Book, dated 04/03/2025 to 07/03/2025 reflected the following ordered and delivery dates for Resident #3's Rivaroxaban 20MG tablet quantity of 14 with each delivery from the facility pharmacy:Ordered 04/10/2025 Received 04/11/2025,Ordered 05/04/2025 Received 05/04/2025,Ordered 05/18/2025 Received 05/19/2025,Ordered 06/03/2025 Received 06/04/2025, andOrdered 06/23/2025 Received 06/25/2025. During an interview with RN C on 07/02/2025 at 2:17 PM, revealed that she had been trained on medication administration. She said that the policy for medication out of stock was to put a note in awaiting the medication delivery. She said depending on the medication staff could pull it out of the e-kit or call the pharmacy for a stat delivery. She said the effects of a resident not getting medication that is prescribed was that by the resident not having the medication, it was not serving the purpose for what the medication was used for. During an interview with Resident #3 on 07/02/2025 at

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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 07/03/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (Resident #3) reviewed for significant medication errors. The facility failed to ensure Resident #3 was administered her Rivaroxaban 20mg tablet (a medication used to prevent blood clot formation to prevent a cerebral infarction, which is a blood clot blockage that impairs blood flow through the brain artery that can lead to permanent disability or even death) scheduled medication on 06/22/2025, 06/23/2025, 06/24/2025 and 06/25/2025. These failures placed residents at risk for complications, as well as jeopardize their health and safety. Findings included: Record review of Resident #3's admission record, dated 07/02/2025, reflected a [AGE] year-old female originally admitted to the facility on [DATE] and last readmitted on [DATE]. Resident #3 had diagnoses that included Type 2 Diabetes Mellitus (a condition that affects how the body uses sugar as a fuel), Senile Degeneration of Brain (a decline in an individual's memory, behavior, and cognitive abilities), Chronic Systolic Heart Failure (an impairment in the heart's ability to fill with and pump blood), Cerebral Infarction (a blood clot blockage that impair blood flow through the brain artery), Chronic Kidney Disease (an impairment in the kidney's ability to filter out toxins), Anxiety Disorder (intense and excessive worry and fear in response to real or perceived threats), Essential Hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (a chronic lung disease that limits airflow and causes ongoing respiratory symptoms), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Paroxysmal Atrial Fibrillation (an abnormal heart rhythm that is characterized by rapid and irregular beating of the upper portions of the heart). 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Record review of Resident #3's care plan, dated 05/09/2022 and last revised 04/26/2025, reflected Focus: [Resident #3] had a cerebral vascular accident (a condition in which poor blood flow to a part of the brain causes cell death). Interventions included: Give medications as ordered by the physician. Observe/document side effects and effectiveness. Record review of Resident #3's Rivaroxaban order dated 10/10/2022 revealed Rivaroxaban Tablet 20 MG Give 1 tablet by mouth in the evening for Heart valve condition give with the evening meals. Record review of Resident #3's Medication Administration Record (MAR) for Rivaroxaban reflected the medication was scheduled to be given with the evening meal. 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