

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 01/29/2026
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #2 and Resident #3) of six residents review for resident rights. The facility failed to keep Resident #2's bell within reach to call for assistance. The facility failed to provide an alternative way for Resident #3 to call for staff assistance. These failures place residents at risk of not getting their needs met timely. Findings included: Review of Resident #2's face sheet printed 01/29/2026 reflected a [AGE] year-old female who was admitted on [DATE] with remission date of 12/15/2022 with the following dx: Osteoarthritis to the right shoulder (a degenerative condition where cartilage wears down, causing pain, stiffness, grinding (crepitus), and reduced range of motion, often affecting sleep), Osteoarthritis of the knee, Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease-primarily caused by smoking-that causes airflow obstruction, making it difficult to breathe.), Muscle weakness, pain specific joints, history of falling. Review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score 15, indicating no cognitive impairment. Section GG functional Abilities reflected 3 for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) which indicated Resident #2 required Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunks or limbs, but provides less than half the effort. Toilet transfer 1- The ability to get on and off a toilet or commode. Dependent - Helper does ALL of the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the residents to complete the activity. Review of Resident #2's care plan initiated 03/24/2025 reflected Resident #2 had pain r/t impaired mobility, neuropathy (nerve damage or dysfunction that causes symptoms like numbness, tingling, pain, muscle weakness, and loss of coordination, and can also affect body functions like digestion and blood pressure.), right shoulder pain, joint pain, had an actual fall with Poor Balance, Unsteady gait, impaired physical functioning r/t debility, cognitive impairment. Review of Resident #3's face sheet printed 01/29/2026 reflected a [AGE] year-old female who was admitted on [DATE] with readmission date of 12/06/2023 with the following dx: Repeated falls, Muscle weakness, lack of coordination, other abnormality of the gait and mobility, need for assistance with personal care. Review of Resident #3's admission MDS assessment dated [DATE] reflected a BIMS score 10, indicating moderate cognitive impairment. Review of Resident #3's care plan initiated 10/27/2024 reflected Resident #3 had impaired cognitive function/dementia or impaired thought processes r/t Dementia, Difficulty making decisions, impaired decision making, psychotropic drug use, impaired physical functioning r/t debility, cognitive impairment. Observation on 01/29/2026 at about 09:40 am with the Maintenance Director, in Resident #2 and Resident #3's room revealed their call light system was not functioning, and the entire box was out of the wall. It was observed Resident #2's call button was placed on the bed within reach even though it was non-functioning and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455638	Facility ID: 455638 If continuation sheet Page 1 of 9

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a bell on top of Resident #2's nightstand was out of reach. Observation also revealed Resident #3's call light was placed within reach even though it was non-functioning. There was no visible bell for Resident #3. During an interview on 01/29/2026 at 09:43 am the Maintenance Director stated the call system in Resident #2 and Resident #3's room broke sometimes last week and he had ordered a replacement part. The Maintenance Director stated he gave both residents bells to use until the call system was replaced. The Maintenance Director stated he verbally told staff of the broken call system. The Maintenance Director stated the nursing staff put in maintenance requests in the facility's TELS system (Streamlines maintenance, housekeeping, and repairs, allowing staff to track, manage, and complete tasks efficiently.). The Maintenance Director stated he checked the TELS system daily in addition to his daily routines. The Maintenance Director stated he tried to address concerns within a day or at most 72 hours based on the priority of the concern. During an interview on 01/29/2026 at 09:47 am Resident #2 stated her call system had been broken for about 6 months. Resident #2 stated she was not able to reach the bell on the nightstand. Resident #2 stated whenever she needed help, she would go to the restroom and use the call button in the restroom. Resident #2 stated she was not able to use the toilet in the restroom, she only goes to the toilet to use the call button to call for help. During an interview on 01/29/2026 at 09:51 am Resident #3 stated she did have a bell to call for help as needed. Resident #3 stated she sometimes yells to call for help. During an interview on 01/29/2026 at 1:05 pm the DON stated she was aware of the call system problem in Resident #2 and Resident #3's room. The DON stated she was not sure of how long the call system in their room had been broken but the Maintenance Director was working on it. The DON stated the Maintenance Director had given Resident #2 a bell to call for help. The DON stated the bell was supposed to be positioned within Resident #2's reach, where she could be able to use it, and if she was not able to reach the bell, it was a safety issue. During an interview on 01/29/2026 at 1:49 pm the Administrator stated he was aware Resident #2, and Resident #3's room call system was broken and they were given a bell. The Administrator stated the call system had been broken for a couple of months, maybe 2 months. The Administrator stated he expected the staff to make frequent rounds to Resident #2 and Resident #3's room and place the bell within Resident's reach as if it was the call light, and if not there was a problem. The Administrator stated any damage to the facility should be fixed immediately. Review of facility's TELS documentation reflected: Order # 2891-- Call light malfunctioning. Unscrewed and unplugged from wall-undated -medium priority-room [Resident #2 and Resident #3's room number] Order # 3053- Call light completely broken out of wall, separated from wiring-dated 12/12/2025-medium priority-room [Resident #2 and Resident #3's room number]. Review of facility's invoice completed by the Maintenance Director dated 11/18/2025 reflected: Patient Station, Bedside: 0.25 Dual 2-Jack 2-Gang Replacement Patient Station Review of facility's policy titled Accommodation of Needs revised 06/06/2025 reflected: Policy: The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodation for the individual needs and preferences of a resident, except when the health and safety of the individual or other resident would be endangered. Policy Explanation and Compliance Guidelines: 1. The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom and bedroom and the common living areas within the facility. 2. The facility will ensure that common areas frequented by residents are accommodating physical limitations and enhance their abilities to maintain independence. 3. Facility staff shall make efforts to reasonably accommodate the needs and preference of the resident as they make use of their physical environment. 4. Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and wellbeing to the extent</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>possible. Review of facility's policy titled Resident Rights dated 2018 reflected: Policy statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: a. a dignified existence. b. be treated with respect, kindness, and dignity.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to develop and implement a person-centered comprehensive care plan for each resident consistent with resident rights set forth that include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. for one (Resident #1) of six residents reviewed for care plan. The Facility failed to include in Resident #1's care plan that she needed 2-person physical assist with transfer via mechanical lift. The facility failed to have an order for Resident #1 to be transferred via mechanical lift. This deficient practice placed Residents at risk for not getting the right interventions, risk for harm and hospitalization. Findings included: Review of Resident #1's face sheet printed 01/29/2026 reflected a [AGE] year-old female who was admitted on [DATE] with the following dx: Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease-primarily caused by smoking that causes airflow obstruction, making it difficult to breathe.), Muscle weakness, pain unspecified, Type 2 Diabetes Mellitus with unspecified complications (is a chronic metabolic condition where the body resists insulin or fails to produce enough, causing high blood sugar.), cerebral infarction (a critical medical condition where restricted blood flow causes tissue death (necrosis) in the brain.). Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score 11, indicating moderate cognitive impairment. Section GG functional Abilities reflected 1 for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) which indicated Resident #1 was Dependent - Helper does ALL of the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident #1's care plan initiated 10/25/2025 reflected Resident #1 was at risk for pressure injury r/t (specify) decreased bed mobility/transfers, incontinence, poor nutrition, hx of skin breakdown, fragile skin, Braden risk score [a tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers (bedsores), with lower scores indicating higher risk and scores ranging from 6 (highest risk) to 23 (no risk)], sensory perception). Resident #1's care plan did not address ADLs and means of transfers. Review of Resident #1's mode of transfer printed on 01/29/2026 from the CNA Kardex (is a centralized, frequently updated, and easy-to-reference paper or electronic system that provides a concise summary of essential patient information, including daily care plans, medication, and, allergies) reflected: GG-CHAIR/BED-TO-CHAIR TRANSFER: The ability to transfer to and from a bed to a chair (or wheelchair) 2 person. Review of Resident #1's physician orders reflected no order for mechanical lift transfer. During an interview on 01/29/2026 at 1:05 pm the DON stated if a resident required a mechanical lift transfer, there would be a physician order. The DON also stated the staff would know a resident required a mechanical lift transfer from daily shift change report. The DON stated the CNAs would know a resident required a mechanical lift transfer from the Kardex. The DON stated there was safety issue if there was no order for mechanical lift transfer and the Resident was not care planned for mechanical lift transfer. The DON stated she initiated an in-service on mechanical transfers. During an interview on 01/29/2026 at 2:27 pm the MDS nurse stated she was responsible for completing care plans. The MDS Nurse stated Resident #1's mechanical lift transfer was supposed to be care planned and she must have overlooked it. The MDS Nurse stated the CNAs always look in the Kardex to provide care for Residents and Resident #1's mode of transfer was in Kardex. The MDS Nurse stated she just updated Resident #1's care plan when it was brought to her attention by the DON. The MDS Nurse stated every care area of a Resident was supposed to be care planned. The MDS Nurse stated it was noted in</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1's MDS that she was dependent on staff for transfers. Review of facility's policy titled Comprehensive Care plan revised 05/05/2025 reflected: Policy:It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Definitions:Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Policy Explanation and Compliance Guidelines:The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated.2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the residents' preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicablephysical, mental, and psychosocial well-being.b. Any services that would otherwise be furnished, but are not provided due to the resident 'sexercise or his or her right to refuse treatment5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive, quarterly MDS assessment and when a resident experiences a status change.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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, interviews, and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for mechanical lift transfer. The facility failed to ensure Resident #1 was transferred safely when CNA A transferred her by mechanical lift by herself on 01/29/2026. This failure placed residents at risk of injury. Review of Resident #1's face sheet printed 01/29/2026 reflected a [AGE] year-old female who was admitted on [DATE] with the following dx: Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease-primarily caused by smoking-that causes airflow obstruction, making it difficult to breathe.), Muscle weakness, pain unspecified, Type 2 Diabetes Mellitus with unspecified complications (is a chronic metabolic condition where the body resists insulin or fails to produce enough, causing high blood sugar.), cerebral infarction (a critical medical condition where restricted blood flow causes tissue death (necrosis) in the brain.). Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score 11, indicating moderate cognitive impairment. Section GG - functional Abilities and goal reflected 1 for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) which indicated Resident #1 was Dependent - Helper does ALL of the effort. Residents do none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident #1's care plan initiated 10/25/2025 reflected Resident #1 was at risk for pressure injury r/t (specify) decreased bed mobility/transfers, incontinence, poor nutrition, hx of skin breakdown, fragile skin, braden risk score [a tool used by healthcare professionals to assess a patient's risk of developing pressure ulcers (bedsores), with lower scores indicating higher risk and scores ranging from 6 (highest risk) to 23 (no risk)], sensory perception). Resident #1's care plan did not address ADLs and means of transfers. Review of Resident #1's mode of transfer printed on 01/29/2026 from the CNA Kardex ((is a centralized, frequently updated, and easy-to-reference paper or electronic system that provides a concise summary of essential patient information, including daily care plans, medication, and, allergies) reflected: GG-CHAIR/BED-TO-CHAIR TRANSFER: The ability to transfer to and from a bed to a chair (or wheelchair) 2 person. During an observation on 01/29/2026 at about 10:10 am, CNA A was observed transferring Resident #1 all by herself without another staff present from Resident#1's bed to the chair via mechanical lift. The DON then walked to the scene and stated 2 people were needed for mechanical transfers. During an interview on 1/29/2026 at 10:12 am CNA A stated she had been trained on mechanical transfers and 2 people were required for mechanical transfers. CNA A stated 2 people were needed for the safety of the residents and staff. CNA A stated Resident #1 was her family member, and Resident #1 kept telling her (CNA) to get her (Resident #1) up quickly. CNA A stated the other CNA on the hall was busy and she did not have anyone else to help her that is why she transferred Resident #1 via mechanical lift all by herself. During an interview on 01/29/2026 at 1:05 pm the DON stated 2 people needed to transfer a resident via mechanical lift, and this was done for safety, spotting, and making sure the transfer was done safely. The DON also stated the staff would know a resident required a mechanical lift transfer from daily shift change report. The DON stated the CNAs would know a resident required a mechanical lift transfer from the Kardex. The DON stated she initiated an in-service on mechanical transfers. During an interview on 01/29/2026 at 2:27 pm the MDS nurse stated she was responsible for completing care plans. The MDS Nurse stated Resident #1's mechanical lift transfer was supposed to be care planned and she must have overlooked it. The MDS Nurse stated the CNAs always look in the Kardex to provide care for Residents and Resident #1's</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>mode of transfer was in Kardex. The MDS Nurse stated she just updated Resident #1's care plan when it was brought to her attention by the DON. The MDS Nurse stated every care area of a Resident was supposed to be care planned. The MDS Nurse stated it was noted in Resident #1's MDS that she was dependent for transfers. Review of facility's in-services reflected the following: Safe lifting and movement to Residents and Lifting Machine /Mechanical lift dated 05/07/2025-CNA A signed Review of facility's policy titled Lifting Machine, using a Mechanical dated 2018 reflected: Purpose -The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. Guidelines At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. (Note: Review Manufacturer guidelines for specific machine use/directions) Review of facility's policy titled Safe Resident Handling/Transfers revised 05/05/2025 reflected: Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the residents while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Compliance Guidelines: 3. Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies. 4. Mechanical lifts may include equipment such as full body lifts, sit-to-stand lifts, or ceiling track mounted lifts Two staff members must be utilized when transferring residents with a mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. 12. The staff must demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency placed in their education file. 13. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care. 15. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device. Review of facility's policy titled Accident and Supervision revised 05/16/2025 reflected: Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions: Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident. Hazards refers to elements of the resident environment that have the potential to cause injury or illness. Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident. Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 5- Supervision-Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency b. Based on the individual resident's assessed needs and identified hazards in the resident environment.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observations, interviews and record review, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for two (Resident #2 and Resident #3) of six residents reviewed for resident call system in that: Resident #2 and Resident #3 did not have a properly functioning call system in their room from 11/18/2025 to 01/29/2026. This failure placed residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included Observation on 01/29/2026 at about 09:40 am with the Maintenance Director, in Resident #2 and Resident #3's room revealed their call light system was not functioning, and the entire box was out of the wall. It was observed Resident #2's call button was placed on the bed within reach even though it was non-functioning and a bell on top of Resident #2's nightstand was out of reach. Observation also revealed Resident #3's call light was placed within reach even though it was non-functioning. During an interview on 01/29/2026 at 09:43 am the Maintenance Director stated the call system in Resident #2 and Resident #3's room broke sometimes last week and he had ordered a replacement part. The Maintenance Director stated he gave both residents bells to use until the call system was replaced. The Maintenance Director stated he verbally told staff of the broken call system. The Maintenance Director stated the nursing staff put in maintenance requests in the facility's TELS system (Streamlines maintenance, housekeeping, and repairs, allowing staff to track, manage, and complete tasks efficiently.). The Maintenance Director stated he checked the TELS system daily in addition to his daily routines. The Maintenance Director stated he tried to address concerns within a day or at most 72 hours based on the priority of the concern. During an interview on 01/29/2026 at 09:47 am Resident #2 stated her call system had been broken for about 6 months. Resident #2 stated she was not able to reach the bell on the nightstand. Resident #2 stated whenever she needed help, she would go to the restroom and use the call button in the restroom. During an interview on 01/29/2026 at 1:05 pm the DON stated she was aware of the call system problem in Resident #2 and Resident #3's room. The DON stated she was not sure how long the call system in their room had been broken but the Maintenance Director was working on it. The DON stated the Maintenance Director had given Resident #2 a bell to call for help. During an interview on 01/29/2026 at 1:49 pm the Administrator stated he was aware Resident #2, and Resident #3's room call system was broken and they were given a bell. The Administrator stated the call system had been broken for a couple of months, maybe 2 months. The Administrator stated any damage to the facility should be fixed immediately. Review of facility's TELS documentation reflected: Order # 2891-- Call light malfunctioning. Unscrewed and unplugged from wall-undated -medium priority-room [Resident #2 and Resident #3's room number] Order # 3053- Call light completely broken out of wall, separated from wiring-dated 12/12/2025-medium priority-room [Resident #2 and Resident #3's room number]. Review of facility's invoice completed by the Maintenance Director dated 11/18/2025 reflected: Patient Station, Bedside: 0.25 Dual 2-Jack 2-Gang Replacement Patient Station Review of facility's policy titled Accommodation of Needs revised 06/06/2025 reflected: Policy: The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodation for the individual needs and preferences of a resident, except when the health and safety of the individual or other resident would be endangered. Policy Explanation and Compliance Guidelines: 1. The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom and bedroom and the common living areas within the facility. 2. The facility will ensure that common areas frequented by residents are accommodating physical limitations and enhance their abilities to maintain</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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>independence.3.Facility staff shall make efforts to reasonably accommodate the needs and preference of the resident as they make use of their physical environment.4.Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and wellbeing to the extent possible. Review of facility's policy titled Safe and Homelike Environment dated 06/15/2025 reflected: Policy:In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.</p>		