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	04/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to provide adequate supervision and assistance devices to prevent accidents for 1 of 6 (Resident #1) reviewed for accident hazards and supervision.The facility failed to ensure Resident #1 was properly secured in her wheelchair on 4/20/2026, which resulted in the resident slipping out of her wheelchair onto the floor of the vehicle and suffering a fractured toe and shoulder pain.This failure placed the residents at risk of serious harm and a diminished quality of life.Findings included:Record review on 4/23/2026 of Resident #1's admission record reflected a [AGE] year-old female, originally admitted to the facility on [DATE]. Record review on 4/23/2026 of Resident #1's diagnoses report reflected the following diagnoses in part: End Stage Renal Disease (kidney failure), Other Specified Disorders of Bone Density and Structure, Unspecified Site (abnormal bone density), Nondisplaced Fracture of Third Metatarsal Bone, Right Foot, Subsequent Encounter for Fracture with Routine Healing (less severe bone crack of the right toe closest to the little toe which remained in its normal position healing normally), Systematic Involvement of Connective Tissue (group of disorders that affect the connective tissues, which provide support and structure to various organs, joints, and other body systems), Unspecified Dislocation of Left Shoulder Joint, Sequela (abnormal bone density or structure localized to the left shoulder that is a residual effect of a prior injury, surgery or disease) onset 5/19/2025, Other Chronic Pain onset 5/28/2025, and Unspecified Osteoarthritis (breakdown of cartilage leading to pain, stiffness, and loss of mobility).Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 13, indicating intact cognitive functioning. Resident #1 required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts,holds, or supports trunk or limbs, but provides less than half the effort) rolling left to right and moving from sitting to lying. Resident #1 was dependent (Helper does ALL of the effort. Resident does 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) for transfers.Record review of Resident #1's Order Summary Report on 4/23/2026 revealed active orders for: renal dialysis dated 6/4/2025 to be conducted on Monday, Wednesday, and Friday, with chair times at 6:15 am-11:25 am per facility staff; Monitor circulation sensation and movement. [Insure] boot to the Right foot is not [to] tight. [Notified] provider immediately for signs of impaired circulation or increased pain. every shift for Fractures toes, dated 4/23/2026; place gauze or padding between 2nd and 3rd digit on right foot secure with medical tape, ensure circulation is not impaired, reapply daily monitor for pain discoloration swelling or numbness and report changes every shift for fracture stabilization, dated 4/21/2026. Record review of Resident #1's care plan on 4/23/2026 reflected the following focus items and interventions in part: Resident #1 has Impaired physical functioning r/t debility/weakness, fatigue, limited ROM, musculoskeletal impairment; UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE; CONTRACTURE, LEFT HAND; POLYNEUROPATHY, UNSPECIFIED; UNSPECIFIED DISLOCATION OF LEFT SHOULDER JOINT, SEQUELA, initiated 11/24/2025 and revised 04/23/2026. Utilizes Hoyer lift and 2 staff for transfers, initiated 03/03/2026, revised on 03/03/2026. Utilizes the following for mobility: Motorized Wheelchair (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 04/23/2026
NAME OF PROVIDER OR SUPPLIER Greenview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Owen LN Waco, TX 76710	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Sometimes Manual wheelchair (Dependent) with certain transport, initiated on 3/03/2026, revised on 03/03/2026. Resident #1is at risk for complications r/t Boot/Shoe to the right foot, initiated on 4/23/2026, revised on 4/23/2026. Resident #1 is at risk for pain r/t chronic disease processes, musculoskeletal abnormalities/diseases AEB DX: UNSPECIFIED DISLOCATION OF LEFT SHOULDER JOINT, SEQUELA SYSTEMIC INVOLVEMENT OF CONNECTIVE TISSUE, UNSPECIFIED NONDISPLACED FRACTURE OF THIRD METATARSAL BONE, RIGHT FOOT, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING, initiated on 9/22/2025, revised 4/23/2026. Potential for complication r/t fracture of right third toe AEB DX: NONDISPLACED FRACTURE OF THIRD METATARSAL BONE, RIGHT FOOT, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING, initiated 4/23/2026 revised 4/23/2026.Record review conducted on 4/23/2026 of Resident #1's progress notes reflected the following: 4/20/2026 07:24 eMAR Note Resident went to dialysis at this time. 4/20/2026 11:50 eMAR Note Resident is complaining right lower leg. Hydromorphone administered per order for pain.4/20/2022 12:00 Post Fall Evaluation Fall Details: Date/Time of Fall: 04/20/2026 1:19 PM Fall was not witnessed. Fall occurred elsewhere. Other fall location: Facility Van while back [form] facility. The reason for the fall was not evident. Did an injury occur as a result of the fall: No. Did fall result in an ER visit/hospitalization: No. Provider: (NP A)Notified of: Unwitnessed fall new orders received; See Provider order sheet. Resident's responsible party notified: Yes.Sister.Details of notification: No [answers] Date of Resident's responsible party notification: 04/20/2026 12:29 PM Contributing Factors.Wheelchair was involved in fall. Wheelchair was not unlocked at time of fall. Wheelchair footrest(s) were not in the way at the time of fall. Footwear at time of fall: Shoes. Resident was not using cane/walker as instructed.Contributing factors note: IT [was happened] outside facility. it [was happened] in facility van.Vitals note: WITHIN NORMAL RANGES.Indicators of pain: Vocal complaints of pain. Pain Issue: #001: New. Location: Generalized. Pain score: 6. Aching. PRN medication provided.4/20/2026 1:17 Nurses Note Facility Van Driver stated that while she back from dialysis center. When she pressed [break], resident [slide] from wheelchair and [fall down]. This nurse went [front] after van arrived. Resident was found sitting on van floor with wheelchair on back. No visible injuries while [do] assessment on van. Resident is [complaining] right leg pain. We transferred back to wheelchair with help of staff and [bring] back to bed. Did assessment again. Vital signs were taken. [Vital s] signs within normal ranges. No injuries noted. Pain pills [given] as order. Notified (NP A) while she is in facility. (NP A) evaluated resident. [Give] x-ray order right femur, foot and knee 2 Views. Administrator. and ADON.aware. Contact Sister.no answered. Resident stated that she will contact sister. Resident is responsible party [self]. Resident aware situation.4/20/2026 1:44 eMAR Note X-ray tech aware. They will come to do later. FEMUR RT 2V* | FOOT RT 2V | KNEE RT 2V** SENT for Imaging 4/21/2026 7:27 AM CT ** one time only.4/21/2026 1:57 Nurses Note This nurse received x-ray right foot x-ray. This nurse [send] to (NP B) to review while she is in facility. NP Reviewed result. Result [show] acute fracture may be present in the neck of the third metatarsal. NP [order] boot and follow up with Podiatry. [Advice] resident not to put [press and] weight [bearing] on that foot. Podiatry will be coming facility to see resident.4/21/2026 2:32 Nurses Note spoke with (NP B), received order to buddy wrap 2nd and 3rd digit on right foot to provide stability to fracture.4/21/2026 3:30 eMAR Note They will come to do x-ray. X-ray tech aware. SHOULDER LT 2V** SENT for Imaging 4/21/2026 2:28 PM CT ** one time only related to OTHER CHRONIC PAIN.4/21/2026 6:11 Nurses Note Unwitnessed fall 1/3 days. Resident is alert and oriented x3. Resident had no visible injuries noted post fall. Resident x-ray done post fall. X-ray report collected and acute fracture noted on third metatarsal. (NP B) [Give] order to fix boot and follow up with Podiatry. Podiatry saw her this shift. Resident is in electric wheelchair all day. Resident is complaining left shoulder pain and NP [give] me order for x-ray. X-ray order put in PCC. This nurse will pass to next shift nurse. nurse to follow up on x-ray.4/22/2026 3:49 Nurses Note (MD B) looked over rsd XR of shoulder advised dislocation and to let (MD A) know to see plan for shoulder. Also advised to send to (NP A). (NP A) approved to send out (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to ER. Prior hx of dislocation on L shoulder. (NP A) okayed to be sent to hospital. Pain med given and sent to (hospital). Sister has been notified, MD and NPs notified4/22/2026 10:26 Nurses Note pt arrived to facility with a new order of Hydrocodone 5-325 mg every 8 hrs. First dose given by ER nurse at 622 pm. [Sated] patient left shoulder chronic dislocation. Boot shoe for the right foot 3rd toe, due to fracture. patient arrived to facility via transport staff from facility. Call light in reach. 4/23/2026 10:29 Skin Check Foot evaluation completed.Record review on 4/23/20256 of Resident #1's neurological evaluation report dated 4/20/2026 revealed neurological checks were started on 4/20/2026 at 12:00 PM and continued every 15 minutes through 4/21/2026 at 16:45 PM. No concerns, changes, or deviations from the resident's baseline noted.Record review on 4/23/2026 of Resident #1's Post Fall Evaluation conducted on 4/20/2026 reflected Resident #1 fell on 4/20/2026 at 13:19 PM with no witnesses to the fall. The fall was shown to have occurred in the facility's van with no injuries and no hospital visit necessary. The NP was notified. Notification contact with the resident's sister was attempted on 4/20/2026 at 12:29 PM. The contributing factor listed was the resident's wheelchair. At 14:26 PM the resident vocalized generalized complaints of moderate pain. PRN medication provided.Record review on 4/23/2026 of Resident #1's hospital discharge paperwork dated 4/22/2026 (printed at 9:52 PM) indicated the resident was given a new prescription for pain medication, recommendations for exercises to relieve should pain, and a fall prevention guide. Imaging tests conducted during the hospital visit included XR Shoulder 2 or More Views Left, and XR Toe 2 or More Views Right. The resident's diagnoses during her hospital visit were chronic dislocation of left shoulder and toe pain, right.Record review on 4/23/2026 of Resident #1's Skin Assessment conducted 4/23/2026 at10:30 AM indicated the resident's right lateral foot was evaluated with no concerns noted.Record review on 4/23/2026 of the facility's in-service records from January 2026 through April 2026 reflected education provided on various topics including Resident Rights, Safe and Homelike Environment, and Transporting a Resident (Facility Van or Vehicle). The in-service on transporting a resident was provided to TR A and TR B only on 4/21/2026 per the staff sign-in sheet.Record review of TR A's personnel file on 4/23/2026 at 1:38 PM revealed the duties and responsibilities of TR A's position as a driver, which was signed by TR A on 4/1/2024. Those duties and responsibilities included immediately reporting to the Program Director any problems observed or encountered while transporting participants.TR A's personnel file also included a Transportation Safety Checklist dated 6/26/2025 in which the former maintenance director verified and signed off on TR A's Wheelchair Transport Driver requirements and skills, visually checking equipment for proper working conditions, fastening restraints, and not starting the vehicle until passengers were properly seated and secured.Record Review conducted on 4/23/2026 at 1:39PM of the written statement of TR A dated 4/22/2026, revealed TR A's account of the incident/accident involving Resident #1 on 4/20/2026. TR A stated she received a call from Resident #1 on 4/20/2026 informing TR A that the resident was finished with dialysis and requested to be picked up. TR A stated when she got to the dialysis center, she proceeded to push the resident up into the van and strap all 4 of the buckles to the wheelchair. She stated she then proceeded back to the facility. TR A stated when she approached the 4-way intersection she began to slow as the light quickly started to change. TR A reported it was then that she heard Resident #1 say she was slipping. TR A stated that she immediately reached back with her arm to try to prevent the resident from further slipping. TR A reported, the next thing she knew was that the resident slipped off of her mechanical lift pad and landed on her bottom. TR A said she immediately asked the resident if she was okay and the resident said yes but told TR A to get her off this floor. TR A stated because the resident required a mechanical lift, she told Resident #1 there was nothing she could do. TR A said she called the facility and told the resident's nurse what happened. TR A stated she asked the nurse to have people waiting when she arrived back at the facility to assist. TR A stated when they arrived staff were waiting and they quickly got the resident back into her wheelchair. The resident was then taken inside to be assessed by her nurse. Record review conducted on 4/23/2026 at 3:53 PM of TR B's personnel file. TR B was the back-up van driver (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	for the facility. TR B's primary position at the facility was a CNA. Included in the file were copies of TR B's orientation and training conducted on 7/4/2025. There was no evidence of a transportation skills checklist in TR B's file.Record review conducted on 4/23/2026 at 3:53 PM of AD's personnel file. AD was not the facility's primary or secondary driver, but was trained and authorized to transport residents, if necessary. AD signed her orientation for the AD position 2/9/2023. AD's file contained a Motor Vehicle Record Questionnaire completed by AD on 11/17/2021 in which she denied committing any major driving infractions or committing motor vehicle crimes. A driving record was requested for AD on 11/18/2021 by the administrator at that time. The form shows the submission was accepted. The instructions on the form stated that the form was to be completed annually to obtain/maintain driving privileges. There was no additional evidence in the file that suggested any further driving record checks were completed.Record review conducted on 4/23/2026 at 4:42 PM of the facility's new transportation/driver safety checklist provided by FD. The form was not completed but was provided as evidence of the facility's intention and plan moving forward. The checklist included running driving record and license verifications, verbalization and demonstration of the safe and proper use of vehicle equipment.During an observation and interview of Resident #1 on 4/23/2026 at 10:58 AM, the resident was observed in the lobby area of the facility in her motorized wheelchair. She was casually speaking and interacting with staff and others. Resident #1 was observed to be dressed in her own clothing that was appropriate for the weather and time of day. Her hair was neatly braided. Her hygiene appeared good. The resident was wearing soft open-toe medical shoe or boot on her right foot and her toes were visible. The resident was not wearing a sock on her right foot. No discoloration or swelling was noted, and the resident did not exhibit obvious signs of pain or discomfort and denied such. The resident's mobility within her motorized chair did not appear to be restricted. Resident #1 said she attended dialysis several days a week. Resident #1 confirmed she was transported to those appointments and back by facility staff in the facility's transportation vehicle. The resident said she was not good when asked how she was doing. I advised the Resident that I would check back with her in her room privately and she agreed.In an interview on 4/23/2026 at 11:28 AM, Resident #1 stated that TR A picked her up from dialysis on 4/20/2026 in the facility's van. She stated TR A was the only person in the vehicle. Resident #1 said while returning to the facility in the van, she slid out of her wheelchair onto the floor of the van. Resident #1 said TR A anchored her wheelchair into the van, but TR A stated she was not secured in her wheelchair with a seat belt of any kind. Resident #1 said she was using a manual wheelchair at that time. Resident #1 said she preferred to use her motorized wheelchair, but she is not allowed to when being transported in the facility van due to her motorized wheelchair's size. Resident #1 said she slid all the way out of her chair onto the floor. She said TR A said she couldn't pick her up off the floor because no one was there to assist. Resident #1 said she was on the floor until they arrived back at the facility. She estimated this to be approximately 30 minutes. Resident #1 said she was attending dialysis when TR A picked her up. Resident #1 said she broke her toe and dislocated her shoulder as a result. Resident #1 said her toes were x-rayed the same day as the incident. She said her shoulder was x-rayed on 4/22/2026 after she started experiencing shoulder pain. She said she wasn't in serious or uncontrolled pain now. She said overall she was okay. She was just upset that the incident happened. Resident #1 stated overall the staff were attentive and caring, including TR A. In an interview on 4/23/2026 at 11:34 AM, the ADM stated he had been employed with the facility for over 1 year. The ADM stated TR A had been employed as a driver with the facility for more than 3 years. The ADM stated TR A did not report the incident involving Resident #1 to him or a supervisor. He said he was not made aware of the incident until the day after the incident because he had been out of the office. ADM stated TR A was suspended when he learned of the incident and while he investigated. ADM stated that he obtained a written statement from TR A. ADM stated TR A picked up the resident from the dialysis center and she was in a hurry. ADM said TR A didn't strap the resident into her chair properly and she slid out of the chair. ADM said TR A stated she hit the brakes as she approached a traffic light, causing Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#1 to slide out of her chair. ADM said TR A stated that she utilized the manual floor anchors to secure the wheelchair to the floor of the van but didn't use the cross belt to secure the resident in the chair. ADM stated that TR A said she attempted to fasten the cross belt, but it didn't fit. ADM said the incident happened nearby, so the resident was not on the floor long. He said the incident happened around the corner. ADM stated that TR A was alone with the resident when she slid out of her chair, so she called ahead to facility staff to inform them of their need for help. ADM stated that all necessary staff were outside waiting when they arrived. ADM stated that the resident was reportedly crying when they arrived and told staff to get her up. ADM said he implemented an employee plan with TR A and he will be terminating her employment. ADM stated that TR A had never been accused or abuse, neglect, or mistreatment of any resident. ADM stated that TR A had not been involved in an incident such as this while employed with this facility, but she was involved in a similar incident while employed at another facility. He said documentation regarding the prior incident was maintained in TR A's personnel file because the incident was at a sister facility. ADM stated he had the maintenance director conduct a maintenance evaluation of the vehicle to ensure the safety equipment was functioning properly. He said the maintenance director reported the vehicle and its safety equipment were functioning properly and not in need of replacement or repair.In an interview on 4/23/2026 at 11:53 AM, DON stated she was not made aware of the incident involving Resident #1 at the time it occurred. The DON said she learned of the incident when she pulled her daily reports and read about it the next day. DON said she made the ADM aware of the incident upon learning of it. She said the ADM had been out of the facility at the time. DON said the notes she reviewed weren't immediately alarming, but she did question what happened and how it happened. DON said she began investigating the incident by talking to Resident #1. DON said Resident #1 told her that she was asleep and slid out of her chair. DON said the appropriate nursing actions were taken in response to the incident. DON said the resident was assessed, notifications were made, and orders were obtained for an x-ray of the resident's foot, as that was the resident's only complaint at the time. DON said there was no reason for an orthopedic consultation, and the podiatry service provider was already scheduled to see Resident #1 the following day. She said the NP was onsite when the x-ray results were received. The NP reviewed the results and advised staff to buddy wrap the toe, which was common with the type of injury the resident sustained. A medical boot was also recommended but the resident refused. She said after speaking to Resident #1, she interviewed TR A. The DON stated TR A said Resident #1 slipped out of her wheelchair during transport when TR A came to an abrupt stop. She said she was unable to lift the resident back into her chair because the resident required a mechanical lift. DON said TR A and the resident were the only ones in the vehicle. DON said she told TR A not to transport any resident until further notice and to have no contact with Resident #1. DON said she provided an in-service to both facility drivers and instructed the assistant driver to conduct resident transports. The DON stated TR A was suspended pending ADM's investigation. DON also instructed TR A to write a statement of the events. The DON said the resident expressed no out of the ordinary pain or distress, but she did complain of shoulder pain to DON. DON said x-rays were ordered and PRN pain medication was administered in response to the resident's complaint. DON said Resident #1 had a prior diagnosis of a right shoulder dislocation in 2025, so her complaint of shoulder pain was not new. DON said the results of Resident #1's shoulder x-rays were sent to the doctor, but the doctor did not immediately respond. Because of the delay, DON said she sent Resident #1's x-rays to radiology too and asked for a comparison between last year's results and the current results. They were unsure they could access the former results but said they would attempt to gain access and let DON know. While DON was at the nurses station handling the situation, Resident #1 came up to the desk and again asked what they were going to do about her shoulder pain. DON said she explained to the resident they were waiting for the doctor's review of the x-rays. The nurse stated that no fracture or new injury to the resident's shoulder was identified. In an interview on 4/23/2026 at 12:29 PM, the FD stated that he had been employed with the facility since September 2025 but had almost 10 years (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	implemented and reviewed/revised on 5/16/2025, reflected it was the policy of the facility for staff to utilize the risk management section of PCC to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Those included equipment malfunction, falls, observed accidents/incidents, resident injuries due to staff handling, and injuries of an unknown origin. The policy also reflected steps staff were to take in the event of an accident and/or incident as follows: o In the event of an incident or accident, immediate assistance will be provided to ensure resident safety. o Any injuries will be assessed by the licensed nurse or practitioner. First aid will be given for minor injuries such as cuts or abrasions.o The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events.o In the event of an unwitnessed fall or head trauma, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner. Online record review conducted on 4/23/2026 of the eCFR Title 49, Transportation, Subtitle A, Office of the Secretary of Transportation, Part 38, ADA Accessibility Specifications for Transportation Vehicles, Subpart B, Buses, Vans and Systems, Section 38.23, Mobility aid accessibility, (d) Securement devices, (7) Seat belt and shoulder harness, reflected the following: For each wheelchair or mobility aid securement device provided, a passenger seat belt and shoulder harness, complying with all applicable provisions of part 571 of this title, shall also be provided for use by wheelchair or mobility aid users. Such seat belts and shoulder harnesses shall not be used in lieu of a device which secures the wheelchair or mobility aid itself.